GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Rwanda Case Study

Final Version – August 2009

Javier Martinez & Leonard Karasi

Submitted by

HLSP
5-23 Old Street, London,
EC1V 9HL, UK

T +44 (0)20 7253 5064
F +44 (0)20 7251 4404
E enquiries@hlsp.org

www.hlsp.org

Group Disclaimer

This document has been prepared for the titled project or named part thereof and should not be relied upon or used for any other project without an independent check being carried out as to its suitability and prior written authority of HLSP being obtained. HLSP accepts no responsibility or liability for the consequences of this document being used for a purpose other than the purposes for which it was commissioned. Any person using or relying on the document for such other purpose agrees, and will by such use or reliance be taken to confirm his agreement, to indemnify HLSP for all loss or damage resulting therefrom. HLSP accepts no responsibility or liability for this document to any party other than the person by whom it was commissioned.

To the extent that this report is based on information supplied by other parties, HLSP accepts no liability for any loss or damage suffered by the client, whether contractual or tortious, stemming from any conclusions based on data supplied by parties other than HLSP and used by HLSP in preparing this report.

Table of Contents

Abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
BTC:	Belgium Technical Cooperation
DPs	Development Partners
EDPRS:	Economic Development and Poverty Reduction Strategy
GOR:	Government of Rwanda
GTZ	German Agency for Technical Cooperation
HIV	Human Immune-Deficiency Virus
CBPF:	Capacity Building Pooled Fund
HSCG:	Health Sector Cluster Group
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
KFW	German Development Bank
JHSR	Joint Health Sector (annual) Review
MDGs:	Millennium Development Goals
MMR	Maternal Mortality Ratio
MIS	Management Information System
MOH/MINISANTE:	Ministry of Health/ Ministère de la Santé
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NGO:	Non-Governmental Organisation
NHA:	National Health Accounts
PER	Public Expenditure Reviews
PETs:	Public Expenditure Tracking Survey
PFM:	Public Financial Management
PS:	Permanent Secretary
SWAp	Sector –Wide Approach
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Summary of key findings and recommendations

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

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

It also highlights some key issues related to how well the Rwanda HSS intervention fits with GAVI's principles and values.

GAVI HSS Proposal Design, Focus and Rationale

The Rwanda HSS proposal was put together towards the end of 2006 by members of the Inter-Agency Coordination Committee (ICC) comprising MOH, WHO and UNICEF, with close support and involvement from the then Director of Planning and Finance and with the technical support (as consultants) of the School of Public Health of the National University of Rwanda. Districts are the main recipients of the HSS grant and decisions on what should the HSS support were made on the basis of the first district health planning meetings that took place when the new 30 administrative districts were launched in Rwanda as part of the new government decentralisation policy.

The HSS proposal supports 3 main objectives: Accruing the mobilisation and motivation of health personnel / agents for quality PHC; improving the organisation and management of health services at district level; and reinforcing distribution and maintenance systems for medicines, medical consumables, equipment and infrastructure at the district level. The main inputs being supported by the grant include equipment and infrastructure (37%), training and management development (38%) and cash incentives (24%) to be provided as part of the Performance Based Financing (PBF) scheme that operates in Rwanda.

In terms of whether or not the right things were targeted in the proposal it is clear that they were, as Rwanda was and still is trying to reconstruct a health system deeply disrupted by the civil conflict and genocide of the 1990s. There is an issue of why, if the needs, resources and installed capacities in the 30 districts were found to be so different during the district health planning exercise, did the HSS proposal target all districts through the same

generic interventions and provide roughly the same amounts of cash to each. But one should consider the realities that prevailed at the time of HSS design in terms of planning capacity in the MOH and in the districts that would have made it very challenging - or unfeasible - to attempt a more needs-based planning approach.

Our analysis of the counterfactual questions (What would have happened if the GAVI HSS funds had not been made available?) suggests that without GAVI HSS support Rwanda might not have been able to target essential resources to build new district health systems. In that sense GAVI HSS funding was highly strategic and opportune, and fairly flexible too as it gave the MOH complete control on deciding what to fund. The latter, flexibility of donor funding, was not something that the MOH was accustomed to at the time when most funding from health partners came – and still does when Sector Budget Support donors are excluded - with many strings attached.

HSS application, approval and start up measures

The first HSS proposal submitted was approved with clarifications requested by the IRC that Rwanda swiftly responded to. While the sector coordination mechanisms –the Health Sector Cluster Group (HSCG) were informed about the new proposal it cannot be said that they played any role in shaping it, so it is not clear in what way the proposal really complemented or was additional to what other health partners were themselves funding.

Since the HSS money was placed in the same GAVI bank account managed by the MOH, the start up measures were very swift. In retrospect though, greater attention should have been placed on clarifying how the MOH would monitor HSS implementation i.e. how information would be collected, by whom, when, and using which sources. A similar discussion should have taken place to strengthen the national accountability mechanisms of the new HSS grant and its links with the HSCG, and to clarify what part of the MOH would be in charge of HSS monitoring instead of assuming that the EPI directorate should do it just because it had been hitherto the traditional interlocutor and implementing unit for all GAVI grants.

Annual Progress Reporting

These evaluators feel that the level of description and quality of reporting relating to the HSS component of the APR submitted to the GAVI in both 2008 and 2009 was of poor quality and weaker than other sections of the APR report. For example, the reports hardly describe progress even at activity level, or show any examples of good practice or references to any real activity having taken place in the districts.

The APR reporting system was also found to be weakly aligned with both the district and national health planning, reporting and review mechanisms established in Rwanda, such as the Joint Annual Health Reviews. In its current form HSS reporting involves high transaction costs to the MOH, particularly to its under-staffed EPI Directorate. There is also limited involvement of the director of planning and finance or any other senior MOH officer in preparing or reviewing the quality of the APR report. The same can be said about WHO and UNICEF, both of whom support the preparation of the APR but through officers whose main remit is EPI – not health systems strengthening matters. Finally, the APR process takes place completely outside the HSCG or any other sector coordination structures since the ICC (unlike the CCM) does not report to the HSCG.

Based on these observations we recommend a substantial review of how the APR process is conducted in Rwanda. We would suggest that when capacity issues stand in the way of effective HSS reporting specific funding should be made available (preferably as part of the HSS proposal) to support the MOH in the APR preparation. But there is a more fundamental need to review whether the APR process adds any value to the GAVI Secretariat, the IRC model of APR review or the MOH, particularly when other existing options for sector review are already in place and could be used by the GAVI just as other health partners do. For example, the GAVI Secretariat might consider:

- The possibility that a member of the IRC be tasked to attend the Joint Annual Health Sector reviews instead of requiring parallel reporting;
- the possibility of letting Rwanda report according to its fiscal year (that will change in 2010) when annual MOH reports are ready and audits have been approved by parliament;
- the possibility of using established HSSP1 (and now HSSP2) monitoring indicators to monitor HSS instead of selecting different ones proposed by the GAVI.

Progress to date

Given the paucity of information in the APR it is not possible to assess progress to date. HSS funds have been disbursed to spending units (mostly districts and a small share for central MOH) but we do not know much about any positive effects they may have played. Has HSS funding reached all intended districts and health facilities? Were funds received on time and reflected in the district health plans? Have HSS funds (and other MCH related funds) been spent by the districts and health facilities (absorptive capacity) and on the right things? Has HSS funding been matched by other necessary inputs at district/health centre level to bridge the gaps for improved immunisation and MCH services? Is there evidence

that supervision, outreach services and demand generation activities have improved or increased in the 1.5 years of HSS funding? We do not know the answers to any of these questions and, all things considered, we may never see these reported in the APR unless the EPI Directorate modifies its approach to and increases its capacity for performing its national oversight function.

Technical support to the HSS grant

While technical support was available at design it does not look like there is any such support at implementation. Clearly WHO and UNICEF are not receiving requests for, or providing support to the GAVI HSS component, and those managing the HSS grant at the MOH are far too removed from what is going on in the districts for them to be able to assess ant potential technical support needs.

We would recommend that the GAVI prepare specific guidelines depicting the role that technical partners like WHO and UNICEF are expected to play in supporting the HSS grants, both at the time of the APR as well as during implementation. As a minimum, these agencies should assist in the pre-review and validation of data and sources used for HSS reporting in the APR. In the case of implementation the need for technical support should be sourced through existing channels for the delivery of Technical Assistance in Rwanda, including the Technical Capacity Pooled Fund that various health partners contribute to.

How does HSS fit the GAVI principles and values?

Our evaluation suggests that countries like Rwanda are not aware that GAVI expects to see the principles and values discussed in this report as part of its country operations. Some respondents observed that if these principles are important then they should be monitored regularly. A second observation was that while our respondents valued in particular the flexibility of the HSS window and the relative simplicity of the application process these do not feature as explicit GAVI principles of values. The following sections briefly summarise what we found in relation to the GAVI principles as they are applied to the Rwanda HSS grant.

We found the HSS proposal design and application to have been very **country driven**, with strong leadership being provided by the ICC. Respondents valued the flexibility of the HSS funding scheme in terms of allowing the MOH to target its own priorities and the relative simplicity of application. Several respondents observed that while Rwanda may be a small country its needs are not small and that the HSS allocation formula based on births is a disadvantage for "small countries with big needs", like Rwanda.

In terms of HSS **alignment** the picture is mixed. The proposal itself is highly aligned with the health needs and sector priorities of Rwanda, but planning, budgeting, implementation, reporting and monitoring arrangements are not. The APR process in particular seems to involve high transaction costs for little value and it should be thoroughly revised by the GAVI Alliance Secretariat.

The **Harmonisation** of the HSS grant with aid provided by other donors is not clear since HSS matters are seldom if ever discussed at the level (HSCG) where harmonisation might be enhanced. It is also difficult to say if the GAVI HSS funding is complementing other forms of HSS funding, but this was not the fault of the GAVI proposal but the difficulties to track and classify funding provided by health partners, particularly in the districts where HSS operates.

Predictability of funding linked to the HSS grant was considered high by our respondents, who compared it to other sources of funding like donor projects or even the GFATM grants. However, whether the perceived high predictability is being matched by results is not clear: The deficiencies linked to the APR reporting model and related issues made us question whether HSS is really **results oriented and funding linked to performance.**

The GAVI HSS grant was found to be more **accountable, inclusive and collaborative** at design stage than at implementation, when the EPI Directorate has taken full control of HSS but manages it in considerable isolation from other health partners, MOH departments or sector coordination structures.

The **catalytic effect** of the HSS grant was often taken for granted or expected rather than being known or based on verifiable facts. It is likely, however that since the HSS grant supports essential needs like equipment, infrastructure and performance incentives the catalytic effect may be quite hidden. This is not a criticism but an endorsement that certain inputs of limited catalytic effect may be extremely important for poor countries like Rwanda trying to reconstruct their national health system.

The **additionality** of HSS funding (a key prerequisite in the GAVI HSS guidelines) could not be verified by the consultants as this would have required an analysis of resource allocation decisions and outputs at the district level that was not possible. In any case some inputs like equipment, infrastructure and incentives can be easily seen as additional while the same conclusion might be more difficult to make in the case of training and management development where the supply is very uneven, linked to different degrees of donor activity among the 30 Rwandan districts. We the evaluators do not consider that additionality is either an important criterion in the case of HSS or one that can be easily assessed or monitored.

In relation to **sustainability** the evaluators were surprised that with between 24% and 34% of HSS funds going into cash incentives as part of the national PBF scheme the issues around sustainability received so little attention at project design, during proposal clarification or at start up. We were also surprised to verify that none of the three Sector Budget Support partners that we met seemed to be aware that the GAVI is funding performance based incentives.

It is for all these reasons that we recommend that GAVI and the MOH to look into sustainability of PBF funding post GAVI HSS, and why we also recommend that in future, GAVI should not engage in provision of performance incentives without a deeper sustainability assessment that includes a formal discussion with key health sector partners and a more rigorous assessment of how these performance bonuses will be eventually paid and accounted for.

Finally, the focus on **equity** of the HSS proposal was not found to be very strong since all districts are to receive similar inputs regardless of individual needs. However we also consider that it was not possible at the time of design when the district health administrations had just been created and did not probably have the capacity to engage in needs-based planning.

Conclusions

There is ample room for improvement in the implementation of the existing HSS proposal as discussed in this executive summary and report. Most actions relate to what the MOH and its partners might do to improve implementation of the current HSS proposal. However, there is also a need for the GAVI to review some controversial aspects of the GAVI HSS grant management process that may have worked better for vaccination than for HSS matters. The following are some examples:

a) **Improve proposal design and the process of clarifications through a revised IRC model**. The next HSS proposal should be assessed through improved dialogue and understanding of the realities operating in Rwanda than are possible by using a distant, far removed IRC model. When issues of substance are identified at design these should be either resolved or built into the proposal in a constructive manner. This should apply to areas such as: monitoring of results and choice of realistic indicators; alignment of GAVI planning, reporting and funding cycles to those of the country; exploring the room for more progressive grant financing and implementation modalities; and greater attention to sustainability issues when recurrent cost support or cash incentives are provided from the HSS grant. These are just examples, not an exhaustive list.

b) **Improve results orientation and performance monitoring of the HSS grant**. If design and approval process are improved (as above) then the need for a heavy and costly (to the country) APR reporting of the HSS grants would be substantially reduced. The GAVI Alliance should aim at using existing country reporting systems instead or requiring parallel structures and processes. Where reporting systems are found to be weak or unspecific (in terms of the expected HSS results receiving sufficient attention) then the GAVI Alliance should endeavour to strengthen these rather than work around them.

c) **Not all HSS gaps are the same, neither are the risks comparable among different types of HSS proposals**. The GAVI should more clearly distinguish between opportunistic and strategic, innovative or complementary, upstream or downstream HSS proposals, and adjust the risk analysis (and the linked funding decision) to these

realities. Countries taking innovative steps or targeting deeply rooted systemic matters should be treated differently - and the quantities and modalities of funding should be also adjusted - than when more traditional areas are being targeted. There will always be unmet health needs, but the role of the GAVI HSS support should place greater attention to catalytic, strategic unmet health systems barriers.

d) **GAVI HSS is a new form of aid but GAVI is not a standard donor**. The GAVI - through its Secretariat - should stop relating to countries as if it was yet another bilateral agency, particularly on HSS matters where its lack of country presence represents a serious impediment for adequately assessing both opportunities and risks. This distinction is crucial at both design and implementation stages, and was found to be particularly lacking at the latter. Just as GAVI has used the ICC mechanism for vaccine-related matters it should make more and better use of the right sector coordination structures, and these are likely to be different from country to country. Asking for signatures of the HSCG does not guarantee that HSS is being properly coordinated. Where sector coordination arrangements are incipient or weak the GAVI should work with other donors to strengthen these. A once in a year stock taking of progress based on ad-hoc progress reports that are reviewed at a distance by an IRC does not seem to work well for the purposes of monitoring complex HSS interventions.

1 Scope, Approach and Methodology

1.1 Background

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

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

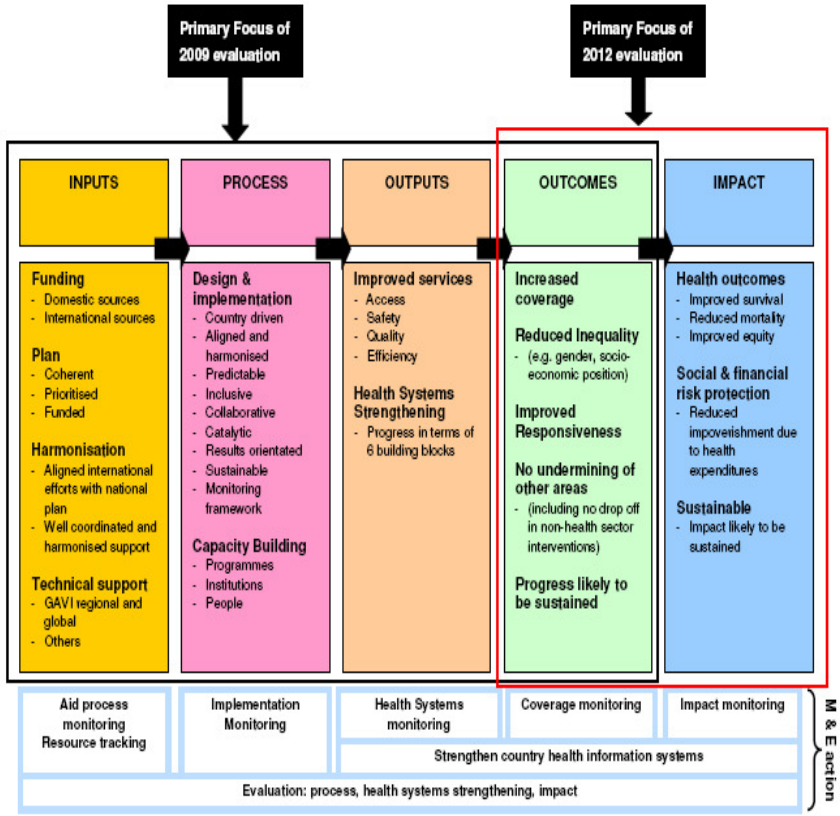
1.2 Brief conceptual framework of the Evaluation

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

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

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation - the first one ever conducted on the GAVI HSS component - focuses primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study also reflects on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

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



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

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

1.3 Approach to the Country Case studies

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

In Rwanda as in other countries the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called "Focal Points" based at either the World Health Organisation (WHO) or UNICEF. It was later found that several people copied in such letters were no longer in post and that new stakeholders had been missed, which is *why this study has recommended the GAVI Alliance Secretariat to review and update the list of country contacts on an annual basis. This will not only help other eventual study teams but will improve effective communications between the GAVI Alliance and the countries, particularly as the GAVI Alliance is not formally present in countries.*

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Rwanda the country visit took place between the 11th and the 22nd of May. This relatively short visit was sufficient given that both authors of this report had previous work experience in Rwanda and were very familiar with its national health system. A list of people met for this evaluation is included in Annex 1. Most meetings took place in Kigali: while field visit to health facilities where discussed they were

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

finally discarded as a possibility on grounds that they would not add much value to available information (particularly as the community based PBF is not operational yet) and that field visits would have taken a disproportionate amount of time from MOH officers in the EPI department at a particularly busy time. Annual reports from a sample of districts were reviewed instead.

After the visit to Rwanda a draft report was prepared that was shared with the Permanent Secretary of the Ministry of Health as agreed with her during our visit. No comments were received on that draft.

1.4 Acknowledgements

We would like to thank the Ministry of Health in Rwanda in the person of the Permanent Secretary for the support received for this evaluation study. Thanks are also expressed to WHO and UNICEF, DFID, BTC, GTZ and the School of Public Health of the National University of Rwanda. The full list of people met for this study is included in Annex 1.

2 Snapshot of the Rwandan health system

2.1 Background to Rwanda

Rwanda is a landlocked country with an estimated population of 9.2 million living within an area of 26,338 km^2. With 350 people per km^2, it is the most densely populated country in Africa. The population growth rate is currently 2.6% and it is estimated that Rwanda will attain a population of 16 million by 2020 if the population growth rate remains unchanged. The EDPRS further reveals that this current population growth rate may slow economic growth and efforts to reduce poverty[2].

It is estimated that 57.5% of the population is below 20 years of age and 45.9% is below 15 years. Of young people under 18 years, 28.6% are considered vulnerable (RDHS 2005) while 23% are raised in female headed households (RDHS 2005). Females account for 52.3% of the population with an average life expectancy of 53.3 compared to 49.4 years for males. The overall life expectancy is 51.4 years.

Rwanda has achieved sustained nominal GDP growth over the last 7 years, rising from RWF 781 billion in 2002 to approximately RWF 2437.2 billion in 2008. Still, in spite of this and many other improvements, per capita GDP (USD 291.3 in 2008) places Rwanda in the poorest category in Sub-Saharan Africa (SSA). This is also reflected in Rwanda's human development index (HDI) which, at 0.452, also places the country in the poorest category in SSA. Poverty is widespread, affecting 57% of the population, while 37% live in abject poverty, showing that the benefits of economic growth are not equitably distributed among the population. This is further demonstrated by Rwanda's 2007 estimated Gini-coefficient of inequality of 0.468, placing it 91 out of 124 ranked countries in terms of inequality (World Bank Development Indicators).

2.2 Health Indicators and progress towards MDGs

As a result of the genocide and civil conflict of the 1990s Rwanda is considerably off track in its progress towards meeting the Child and Maternal mortality MDGs. Infant and under-five mortality have gradually dropped since the mid-1990s but are just returning to pre-genocide levels. Although maternal mortality has declined since the 1994 genocide it remains one of the highest in the world at 750 per 100,000 live births. Child malnutrition would need to

[2] Taken from HSSP II, 2.1 Political, demographic and socioeconomic situation

decline at faster than historic rates. Under-five and infant mortality would need to be reduced by two-thirds within a decade.[3]

Table 1 Progress on health outcomes as per successive DHS surveys

	1992	2000	2005	2007/8
Infant mortality	85/1000	107/1000	86/1000	62/1000
Under-five mortality	150/1000	196/1000	152/1000	103/1000
Maternal mortality	--	1071/100,000	750/100,000	Not measured
Deliveries with skilled attendant	26%	31%	39%	53%
Contraceptive Prevalence Rate	13%	4%	10%	27%
Total fertility rate	6.2	5.8	6.1	5.5

Source: The Millennium Development Goals 4&5 – Maternal and Child Health, by Fidele Ngabo. Powerpoint presentation made at the Joint Annual Health Sector Review, November 2008.

Despite these challenges progress is clearly being made. Between 2000 and 2005, most health indicators returned to pre-genocide levels. Such a rebound can be expected given the exceptional circumstances of the 1990s. The key question is whether the pace of recent (2000-2005) progress can be sustained and accelerated. Some progress has been made in child health, with a steep increase in the proportion of sick children receiving treatment. But much more remains to be done to assure integrated management of childhood illness (including malnutrition and related complications) at facility and community level. There is considerable room for progress in ante-natal (taking advantage that a high proportion of women receive one AN check up in the first 3 months of pregnancy) and in raising the quantity and quality of delivery care.

2.3 The response from the health system

Progress against health outcomes – slow by necessity - should not mask impressive improvements in terms of service delivery and utilisation. For example, the independent Mid Term Review of the Health Sector Strategic Plan I 2005-2009 undertaken in 2008 provided

[3] Most information in this section has been compiled for the Rwanda Service Provision Assessment Survey (RSPA 2008) and from the report by Smithson & Martinez on Progress towards the MDGs in Rwanda.

evidence of considerable improvements in most health and service indicators. Evidence of progress is also reflected in the new HSSP II 2009-2012 to be launched shortly (see Table 2 below).

Table 2 Progress made on key sector indicators

INDICATOR	BASELINE (2005)	HSSP-I target	EVALUATION JUNE 2008	EDPRS revised target for 2012 (2008)
Population (millions)	8.6	NA	9.31	NA
Infant mortality rate / 1000	86 (RDHS, 2005)	61	62 (IDHS, 2008)	70
Under five mortality rate / 1000	152 (RDHS, 2005)	110	103 -IDHS 2008	NS
Maternal mortality rate / 100000	750 (RDHS, 2005)	600	NA	600
Prevalence of underweight (Wt/age)	24.3 (RDHS, 2005)	18	NA	NA
Prevalence of stunting (Ht/age)	45 (RDHS, 2005)	35	NA	27
Prevalence of wasting (Ht/Wt)	4 (RDHS, 2005)	3	NA	NA
Total fertility rate (%)	6.1 (RDHS, 2005)	NA	5.5 (IDHS, 2008)	4.5
Modern contraceptive prevalence rate (%)	10 (RDHS, 2005)	20	27 (IDHS, 2008)	70
Outcome indicators				
% births attended by skilled health workers	31 (RDHS, 2005)	60	52 (IDHS, 2008)	>60
% PW receiving one ANC visit	94 (RDHS, 2005)		98 (HMIS, 2009)	NA
% PW receiving 4 ANC visits	43.5	65	24 (IDHS, 2008)	NA
% youth (15-24 yr) reporting condom use in most recent premarital sex	0.3 (RDHS, 2005)	10	NA	NA
% < 1 yr having received DPT3	86 (RDHS, 2005)	90	95 (IDHS, 2008)	95

Source HSSP II, version July 2009

In spite of impressive results Rwanda still faces huge challenges to bring its health system to the level of the health needs of its population. Coverage of key health interventions remains low in spite of reasonably good geographical access. Significant inequalities exist in service coverage between higher and lower socio-economic groups. The chief reason for this seems to be the inability to afford user-fees and/or health insurance among the poor and the difficulties for static health facilities to reach the un-reached. Low staffing levels continue to hinder health system capacity, particularly in rural areas.

Aware of the deficiencies of a centralised model of service provision (in health as in other public services) the Government of Rwanda engaged in a bold process of decentralisation in 2006. Thirty districts were created, organised, resourced and given ample responsibility for the delivery of essential public services, including health. The policy has the potential to change historical inequalities in resource allocation among and within districts but much remains to be done to strengthen the planning, managerial and monitoring capabilities in the new district health systems and to enhance community-level knowledge and health-seeking behaviour. It was as the new districts were being launched that the HSS grant was designed, thus offering the opportunity for the HSS grant to build up planning and implementation capacity in the new district health administrations.

2.4 Health financing and aid coordination

Although short of the EDPRS target of 12%, the percentage of total GoR budget for health has increased from 8.2% in 2005 to 9.1% in 2007 (PER 2006-2007), translating to a rise of per capita government health expenditure from USD 6 to USD 11. Total health expenditure per capita had risen from USD 17 in 2003 to USD 34 in 2006[4]. The share of the public budget allocated to the health sector (including that for ministries other than the MoH) is 11.4%, still far from the 15% target recommended by the Abuja agreement. Lower than expected nominal public expenditures levels found in the health sector creates sustainability issues as an important part of health expenditures is funded by external sources (about 56% in 2007).

Government health expenditure remains well below the level required to finance a universal essential health package, so several initiatives have been put in place in recent years to compensate for that. Performance Based Financing (still widely known as the contractual approach) combined with the “Mutuelles” scheme (a hybrid of community and government compulsory health insurance) have already demonstrated their worth in raising health care quantity, quality and service utilisation. However, concerns about financial sustainability, inflationary pressures and risk of supply-led demand will need to be resolved. Attention is also required on ensuring that the behaviour of service providers moves beyond static achievement of service targets to a more proactive focus on targeting services to the under-served and to those geographical areas or socio-economic groups concentrating the largest pockets of disease burden at sub-district level. Current government plans to extend the PBF approach to the community level and to reward CHWs for increased case detection and management seem to go in that direction but are still incipient.

[4] NHA 2006

Unequal distribution of donor resources across geographic areas has improved in recent years, partly as a result of improved coordination and dialogue between government and development partners, but the Rwanda health SWAp remains incipient and spending behaviour by development partners still requires a serious overhaul. In spite of efforts to increase Sector Budget Support Mechanisms by several partners (notably Germany, Belgium and the United Kingdom) project-type aid remains the dominant instrument for health aid delivery and its huge transactions costs are very noticeable in all departments of the MOH, including the EPI department where GAVI HSS funds are being managed.

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

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion in 2010. Intentionally, this section will be mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

3.1 HSS proposal design

A small team comprising members of the Inter-Agency Coordination Committee (ICC) for EPI were responsible for putting together the GAVI HSS proposal in late 2006 and early 2007. Key among the ICC members were the EPI coordinator, the (then) Director of Planning and a few officers from WHO and UNICEF responsible for overseeing immunisation services in Rwanda. By then GAVI was already active in Rwanda so these officers were the ones who spotted the opportunity of submitting the first GAVI HSS proposal.

At the time of preparing the HSS proposal the Government of Rwanda had just launched - in January 2006 - the new decentralisation policy that would create 30 multi-sectoral district administrations. It is in the context of the meetings between the MOH and the newly formed district health authorities that district health plans were prepared towards the end of 2006, and it was in these meetings that a number of gaps and barriers to immunisation and to effective service delivery were identified. The EPI officers present in the district planning meetings then used the gaps identified by district health teams to develop the inputs that would be eventually targeted by the GAVI HSS proposal.

There are three main objectives in the Rwanda HSS proposal – all three are strongly linked to the broader health sector strategic objectives that were laid down in the HSSP1:

1. Accrue the mobilisation and motivation of health personnel /agents for quality Primary Health Care;
2. Improve the organisation and management of health services at the district level;
3. Reinforce distribution and maintenance systems for medicines, medical consumables, equipment and infrastructure at the level of district health structures.

In the HSS proposal the above objectives are being pursued through a combination of activities that could be categorised as in the table below.

Table 3 Typology of activities supported by the HSS grant in Rwanda

Specifications	Year1 USD 000	Year 2 USD 000	Year 3 USD 000	Total USD 000	Level			
					National	District	Health center	Village level
Equipment & Infrastructure Subtotals	**1,307**	**383**	**383**	**2,119**				
Activity 1.2.b	60.6	0	0	60.6		X		
Activity 3.1.	40	0	0	40			X	
Activity 3.2	0	20	20	40			X	
Activity 3.3	119.1	159.6	159.6	438.3			X	
Activity 3.4	15	0	0	15	X			
Activity 3.5	10	0	0	10	X			
Activity 3.6	6	6	6	18	X			
Activity 3.7	108	0	0	108			X	
Activity 3.8	850	0	0	850			X	
Activity 3.9	99	198	198	495	X		X	
Training & Management Development Subtotals	**531.4**	**821.4**	**821.4**	**2,174.2**				
Activity 1.3.	510	780	780	2,070				X
Activity 1.4	2.4	2.4	2.4	7.2	X			
Activity 1.5		20	20	40	X			
Activity 1.6	9	9	9	27	X			
Activity 2.8	10	10	10	30	X			
PBF Incentives + programs Subtotals	**334.7**	**510.3**	**510.3**	**1,355.3**				
Activity 1.1	28.5	28.5	28.5	85.5		X	X	
Activity 1.2 a	36	36	36	108		X		
Activity 2.1	16.26	33.58	33.58	83.42		X		
Activity 2.2.	65.52	131.04	131.04	327.6		X	X	
Activity 2.3	75.24	122.4	122.4	320.04		X		
Activity 2.4	18.6	24.6	24.6	67.8		X		
Activity 2.5	9.6	19.2	19.2	48		X	X	
Activity 2.6	70	100	100	270		X		X
Activity 2.7.	15	15	15	45	X			
APPROVED HSS GRANT*	**2,173**	**1,715**	**1,715**	**5,604**				

* Subtotals do not correspond exactly to approved grant because of rounding up.

Did HSS activities address the identified health systems gaps? The health system gaps and barriers that were identified in Rwanda for the HSS proposal originated in perceived needs by districts identified during a planning exercise. However, while district needs were quite

different (as were the levels of per capita health expenditure by district[5]) the HSS proposal chose to target a generic package to be applied to all districts irrespective of their individual needs. While a more needs-based approach to targeting the HSS inputs might have made the HSS ideal it may not have been a feasible option at the time of HSS design, given limited planning and resource allocation capabilities among the 30 new district health administrations that had just been launched as part of the new government decentralisation policy.

Our analysis of the counterfactual questions (What would have happened if the GAVI HSS funds had not been made available?) suggests that without the GAVI HSS support Rwanda might not have been able to target essential resources to build the new district health systems. In that sense GAVI HSS funding was highly strategic and opportune, and fairly flexible too as it gave the MOH complete control on deciding what to fund. The latter, flexibility of donor funding, was not something that the MOH was accustomed at the time when most funding from health partners came - and still does - with many strings attached.

3.2 HSS application and approval processes

In its meeting of 31st January 2007 the ICC made the decision to contract the School of Public Health of the National University of Rwanda as consultants (the consultant) with the objective of moulding and finalising the GAVI HSS proposal. The HSS proposal was in fact just one of three new GAVI proposals being developed at the time, together with a new proposal to apply for the new Pneumococal Vaccine and another one for Immunisation Services Support. The decision to hire a consultant was probably influenced by the availability of the GAVI proposal development fund for a maximum value of $50,000. However, all financial, human and time resources involved in the GAVI HSS proposal preparation were initially covered by the MOH (and in terms of staff costs, by WHO and UNICEF as well), and it is only after approval of the proposal that the GAVI refunded some of the expenses incurred by the MOH through the proposal development fund that was paid through WHO.

At the afore mentioned ICC meeting it was also agreed that once the HSS proposal had been completed it would be sent to the Health Sector Cluster Group (HSCG), the top coordination instrument involving the MOH and its main health partners. Indeed, the Consultant (Maurice Bucagu) presented the GAVI HSS proposal at the 20th February

[5] Several studies have reflected the acute disparities in per capita health financing in Rwandan districts and provinces (see for example Smithson and Martinez 2006). In 2006 the differences in external health funding by various donors reached 2600% between the better and the worst funded provinces.

meeting of the HSCG. Then, at the 20th June meeting of the HSCG the EPI Director (Fidele Ngabo) briefly discussed progress with the HSS proposal and asked HSCG members to provide comments on the clarifications that the MOH had provided to the GAVI.

As will be discussed later the fact that the proposal was presented at the HSCG meeting does not imply that its members were involved in either putting together the said proposal or that they had a clear understanding of how the proposal fit within other health sector investments.

The following box summarises the key dates involved in the HSS proposal preparation and approval:

Box 2. Key dates in the Rwanda HSS proposal

End 2006	District Planning meetings help identify HSS gaps
Jan 2007	ICC discusses HSS proposal and hires consultant
Feb 2007	HSS proposal explained to HSCG
March 2007	HSS Proposal submitted to GAVI
June 2007	Proposal approved with clarifications
July 2007	MOH sends clarifications
8 Aug 2007	Approval decision by GAVI Board
30 Oct 2007	First disbursement received $2,174,000
14 Dec 2007	Second year disbursement approved
Feb 2008	Second disbursement received for $1,715,500
15 May 2008	APR with HSS section submitted by Rwanda

In all, the MOH staff interviewed considered that the proposal design process had been fair in terms of additional workload to the MOH. There was sufficient technical support from WHO and UNICEF to put the proposal together although, in retrospect, it is recognised that the additional needs linked to the monitoring of the HSS proposal did not receive sufficient attention either at design or as part of the start up measures.

3.3 HSS Start-up measures

The implementation of the HSS grant took place from 1st November 2007, the day after the GAVI HSS funds were received in Rwanda. HSS money was placed within the GAVI account held by the MOH. This account is operationally managed by the EPI director (in the sense that the Director EPI sanctions expenditure that is subsequently acted upon by the MOH Finance Director, but the EPI director does not have direct access to the GAVI account). As far as the evaluation team could verify financial transfers of HSS resources

from the said Bank Account have taken place since November 2007 (as per the APR HSS report of FY 2007).

There was not a need for many start-up measures in the case of the HSS funds since the same systems and procedures that already applied to other GAVI grants were used for the HSS grant. However, greater attention should have been placed on clarifying the specific responsibilities of the EPI coordinator in respect to the national oversight of the HSS funds. Similarly, the HSS monitoring arrangements should have been discussed in greater depth and define how information would flow from district health authorities - the main spending units to the EPI coordinator tasked with the oversight role. A similar discussion should have taken place to strengthen the national accountability mechanisms of the new HSS grant and its links with the HSCG, and to clarify what part of the MOH would be in charge of HSS monitoring instead of assuming that the EPI directorate should do it just because it had been hitherto the traditional interlocutor and implementing unit for all GAVI grants.

3.4 Annual Progress Reporting (APR) on HSS

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

In May 2008 the MOH submitted the first GAVI APR report including information on the HSS window. However, the report only covered 2 months of HSS implementation so there is not much to be said in terms of progress, accuracy or relevance of information provided. The evaluation team therefore had high hopes that the HSS information that would be provided in the May 2009 APR covering HSS implementation during 2008 would provide for the first time a more realistic assessment of progress. These consultants had the chance to look at the first draft APR report during the visit to Kigali and then to the final APR report that Rwanda submitted to the GAVI Secretariat. Based mainly on the review of the APR report submitted in 2009 the following observations can be made:

- HSS Activities: There was very limited description of HSS activities. There was no reference made to either the quarterly or annual progress reports that districts submit to the MOH. It was therefore not possible to assess whether, for instance, district level supervision had improved, uptake of services had increased, expected training had taken place or performance incentives had been paid as per the HSS activity plan.
- Financial reporting: All that the APR included were figures of money disbursed to the districts or to other MOH departments as per the original budget, but no mention was

made as to whether the funds received by districts had been actually spent, or on what items they had been spent.

- Result indicators: Reporting on the 6 result indicators included in the original HSS proposal was not clear. For both FYs 2007 and 2008 only three indicators were covered.

The points above suggest that it may not be possible for the Independent Review Committee - APR, tasked by the GAVI Alliance Secretariat to review the APR reports, to make an informed opinion on progress achieved or a recommendation for continued funding. The GAVI Secretariat may also be unable to assess whether or not HSS funds have been used as intended on the basis of the scarce and incomplete financial information provided. Finally, although the HSS proposal (section 7.1) clearly states the need for the HSCG to approve plans and annual budgets, to interpret results and to coordinate the HSS grants with other HSS efforts, this is clearly not happening (see accountability issues in section 4).

All the above merits a detailed discussion in terms of the relevance, alignment and suitability of the APR reporting mechanism in the case of GAVI HSS funding, and on the accountability of GAVI HSS grants. The following points emerge:

1. The draft APR report for FY 2008 that we reviewed was very weak in terms of describing progress even at activity level. It did not show any examples of good practice or references to any real activity in the districts. Although it made reference to district health reports having been used in its preparation there was little evidence of this to be the case.
2. The APR reporting system is not aligned with either the district or national health planning, reporting and review mechanisms established in Rwanda, such as the Joint Annual Health Review that was conducted in November 2008 and March 2009.
3. The reporting on HSS in its current form involves high transaction costs to the MOH, particularly to its EPI Directorate[6]. The APR is prepared primarily by the Director of EPI in collaboration with focal points in WHO and UNICEF. The previous Director of Planning in MoH previously helped in the preparation of the APR, but since a new Director of Planning is now in post who is not so familiar with the GAVI reporting procedures, the role of reporting has been taken on by the EPI Unit. During our

[6] The time and effort involved in GAVI HSS reporting was obvious to the study team as the EPI director was preparing the APR report around the time of our country visit. The EPI director had just one M&E officer to help with the task and no accountant in place to verify the accuracy of financial reporting related to HSS issues. Capacity problems at the EPI level were acknowledged by both WHO and UNICEF even if, surprisingly, these are seldom reported in the standard APR reports.

interviews the Director of EPI raised the constraint of being overloaded by reporting requirements from various donors. For the current APR, WHO has not been able to provide technical support for the preparation of the HSS component of the report because (we were told) the Officer who should have provided that support was acting as Country Representative.

4. The EPI Directorate may not be the most appropriate reporter in the case of HSS matters in Rwanda as these are often outside its remit. In any case the EPI directorate does not have the staff, the time or the resources to effectively report as per the APR format.
5. The reporting on HSS takes place within the EPI directorate and its linked Inter-Agency Coordination Committee (ICC), but it does not formally report through any recognised channel to the HSCG (as the HSS guidelines and the Rwanda proposal recommend). Parallel HSS APR reporting hinders the national accountability of HSS funds through established mechanisms such as the HSCG.

Based on these observations we recommend a substantial review of how the APR process is conducted in Rwanda. We would suggest that when capacity issues stand in the way of effective HSS reporting specific funding should be made available (preferably as part of the HSS proposal) to support the MOH in the APR preparation. But there is a more fundamental need to review whether the APR process adds any value to the GAVI Secretariat, the IRC model of APR review or the MOH, particularly when other existing options for sector review are already in place and could be used by the GAVI just as other health partners do. For example, the GAVI Secretariat might consider:

- The possibility that a member of the IRC be tasked to attend the Joint Annual Health Sector reviews instead of requiring parallel reporting;
- the possibility of letting Rwanda report according to its fiscal year (that will change in 2010) when annual MOH reports are ready and audits have been approved by parliament;
- the possibility of using established HSSP1 (and now HSSP2) monitoring indicators to monitor HSS instead of selecting different ones proposed by the GAVI.

3.5 HSS progress to date

It is hard to assess progress to date in relation to the GAVI HSS grants not because progress is not taking place but because this is not really reflected in the APR report, as discussed earlier.

It is also hard to comment on use of HSS funds to date partly because the figures in the APR report (section 4.2) do not tally and because the amounts reported as spent are in reality transferred funds that may or may not have been spent. So, all that the evaluators were able to do was to refer to the tables on budget execution by programme prepared by the MOH as a proxy for overall use of available funds in Rwanda. As can be seen execution rates are generally above 80% with a few exceptions, but it is hard to assess in what category of the table GAVI funds are included[7].

Table 4 Budget Execution by Programme 2008

	BUDGET (Rec+Dev) (millions of RwF)			RECURRENT BUDGET (millions of RwF)			DEVELOPMENT BUDGET (millions of RwF)		
PROGRAMME	Budget	Execution	Exec. Rate	Budget	Execution	Exec. Rate	Budget	Execution	Exec. Rate
TOTAL	**85 931**	**69 188**	**81%**	**32 536**	**31 518**	**97%**	**53 395**	**37 669**	**71%**
institutional capacity	2 000	1 608	**80%**	998	719	**72%**	1 001	888	**89%**
human resources development	13 916	13 476	**97%**	13 713	13 324	**97%**	203	151	**75%**
financial accessibility	6 292	5 672	**90%**	2 164	2 214	**102%**	4 128	3 458	**84%**
geographical access	8 746	3 046	**35%**	1 366	1 485	**109%**	7 380	1 561	**21%**
drugs vaccines and consumables	3 322	3 342	**101%**	3 322	3 342	**101%**	-	-	**0%**
health care demand and quality	45 256	35 662	**79%**	6 725	6 141	**91%**	38 531	29 520	**77%**
national reference institutions	6 397	6 378	**100%**	4 246	4 290	**101%**	2 151	2 087	**97%**

Source: Adapted from Fidele Karangwa, Finance Director MOH. JHSR March 2009.

3.6 End of HSS Assessment

The improvements/increases in immunisation coverage at the end of the HSS grant are likely to be modest given high immunisation coverage rates in Rwanda that were already high at design stage. It would therefore be better for the purposes of assessing effectiveness and additionality of HSS funding at the end of the HSS grant to assess immunisation coverage

[7] The Budget Execution Report 2008 did not include any GAVI or GAVI HSS specific expenses, so it is not possible to assess expenditure of GAVI funds except by extrapolating general budget execution percentages. The report did however contain GFATM specific expenses, and Vaccine related expenses were reported at 100% execution rate.

rates - and perhaps coverage rates for selective MCH services as well - by district and by health centres within each district instead of using the national consolidated figures. It would also be useful to assess (better than the APR reporting permits) the extent of utilisation of HSS funds by district and by health centres within each district. This exercise would in turn enable **a closer look at the best and worst performing health facilities, and look at their performance in the context of HSS and other inputs (funding, commodities and technical support) received.** This type of analysis would help answer several key questions in relation to HSS support in Rwanda:

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

The above points are important because the HSS grant is partly supporting a scheme - the PBF - where a number of issues linked to provider behaviour are being explored that relate to the risk that more incentives may not lead to more of the right services being provided, or that these services may not reach the underserved (those who do not use health centres but should). A future HSS grant should, in our opinion, improve its targeting on underserved areas instead of delivering the same package of generic inputs to all districts. This could make the HSS grant much more poverty and equity oriented, more demand driven and more focused on the population groups who make less use of health facilities for financial, social or other reasons.

3.7 Support systems for GAVI HSS

Technical support provided by various agencies can be divided into support provided: (a) at proposal design and approval stage; (b) at APR; (c) for HSS proposal implementation. These are briefly reviewed now in the case of Rwanda. Please refer to the typology of HSS support systems in Annex 4.

3.7.1 Technical support for proposal design and approval

As described in sections 3.1 and 3.2 the EPI directorate of the MOH and the planning director at the time received technical support from WHO and UNICEF, its main counterparts on GAVI related and immunisation matters at the Inter-Agency Coordination Committee (ICC) during the proposal design and approval. This included help to respond to the clarifications sought by the IRC of the GAVI. When the MOH decided to hire the School of Public Health of the National University of Rwanda to help prepare the HSS proposal (and also a proposal for introducing the new Pneumococal vaccine) it used its own funds, some of which were later re-funded by the GAVI as part of the New Proposal Preparation fund (for a maximum of $50,000 per new proposal).

Stakeholders who were part of the proposal design process approached by this evaluation team considered that the extent and quality of support received from WHO and UNICEF had been adequate, timely and constructive, and that it built on on-going efforts by these agencies to support the new decentralisation policy in the districts and the preparation of the first district health plans. The GAVI Secretariat undertook a pre-review of the final HSS proposal and did not find any major issues in it except the comment that "..the management and monitoring seems to be weak. There is a request to strengthen the M&E" (page 1 – GAVI 2007). This point is significant given the issues discussed in section 4 of this report on whether GAVI HSS is results orientated.

3.7.2 Technical support to the APR

While both WHO and UNICEF help the EPIU Director prepare the APR the officers who provide such support are versed on EPI rather than on health systems matters. For some reason the WHO officer who deals with health systems matters and attends the HSCG meetings is not the HSS focal point in country, neither is she involved in reviewing and /or helping prepare the HSS section of the APR report. Once the first draft APR has been produced at country level it is sent to the regional focal points for comments, but this year the report had been produced too late for comments to be sought. In sum, the HSS section of the APR is neither checked nor verified outside the unit that is responsible for its implementation, and that unit is mainly concerned with vaccination rather than with HSS matters.

When we discussed the need for validating the HSS information in country with WHO and UNICEF officers it became clear that the rush in which the APR report is put together makes the verification of information a real challenge, particularly in relation to HSS. It was also their view that the process by which WHO or UNICEF should support the APR process in

relation to HSS has been never been made clear to them either verbally or in written form. When we asked about the GAVI annual workplan (where the expected outputs from GAVI collaborating institutions like WHO and UNICEF are discussed) respondents – including the most senior officers mentioned that they were not aware of it.

In conclusion, we would recommend that the GAVI should prepare specific guidelines depicting the role that technical partners like WHO and UNICEF are expected to play in relation to the APR process with specific reference to HSS matters, particularly at national level, which is where such support is most needed. In our view technical support provided by these agencies should assist in the preparation of the HSS report (this takes place already for EPI matters but less so for HSS) and in the pre-review and validation of data and sources used for HSS reporting in the APR.

3.7.3 Technical support for HSS implementation

We did not find any evidence of any systematic, implicit or explicit support being provided by either the WHO or UNICEF in support of implementation of the HSS proposal. This is not meant as a criticism to these agencies: technical support to the MOH at district or central levels, whether for health systems strengthening or for any other topics can and does take place in various forms in Rwanda that may make technical support by WHO or UNICEF unnecessary. For instance, a lot of technical support is being provided either directly by health partners (who still administer significant amounts of technical assistance) or through the Technical Capacity Pooled Fund financed by various donors (Germany, Belgium, United Kingdom and Switzerland) and managed by the MOH.

The need for technically supporting the implementation of the HSS grant was not clear or apparent to many of our interlocutors, including the EPI director. Other MOH officers were of the opinion that "the role of WHO in supporting implementation of GAVI HSS is not visible" particularly as "the GAVI focal point in WHO is more involved in immunization than in HSS matters". In general, the impression of the MOH authorities is that "the role of WHO has been more conventional and not very much at technical support level while the MoH as well as the whole country suffers from lack of competent human resources".

4 Alignment of HSS with GAVI principles and values

This section analyses the extent to which the Rwanda HSS grant adapts to the GAVI principles and values, as described below. Some principles have been slightly modified to incorporate specific questions relevant to this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

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

4.1 Country Driven

As discussed in section 3 the GAVI HSS proposal was clearly country driven by a group of MOH, WHO and UNICEF officers, and with the assistance of the School of Public Health acting as consultant. The original HSS gaps were identified with the help of the first District Health Planning meetings that resulted from implementing the government decentralisation policy and its creation of 30 administrative districts. The involvement of the Health sector Cluster Group - the most important forum on health matters between the government of Rwanda and its Health Partners - was very limited at design. The HSS guidelines expect that such groups will play a key role in ensuring that the HSS grants are, for example, additional and complementary to what other health partners are funding. In Rwanda the HSCG was simply informed that a proposal had been submitted and its main activities were presented, but limited, if any, discussion took place according to the records we checked and the interviews we held with health partners.

At implementation the HSS grant remains country driven, but the leadership is at the level of the EPI directorate with little, if any, involvement of either the Department of Planning and Finance or the HSCG. HSS has thus become another project, but its strategic dimension might easily be lost. The links between the main implementing agents - the districts - and the EPI Directorate on HSS matters was found to be quite weak.

4.2 Is GAVI HSS support aligned?

In this section we consider three dimensions to alignment as discussed in the evaluation study guidelines: Alignment with broader development policies; alignment with planning and reporting systems; alignment with budget mechanism and financial management procedures and systems.

4.2.1 Alignment with broader development and health policies

The focus of the HSS proposal is the mobilisation and motivation of health personnel, the improved organisation and management of health services at district level and the reinforcement of distribution and maintenance systems for medicines, medical consumables, equipment and infrastructure. All these are key objectives of the Health Sector Strategic Plan I (HSSP I), which aims to improve the availability of human resources, drugs, vaccines and consumables; to expand geographical and financial access to health services; to improve the quality of and demand for health services; and to strengthen the sector´s institutional capacity; among other objectives. In this sense the HSS proposal is fully aligned with the HSSP I. Further, the way in which the HSS gaps were identified using the first District Health Planning meetings of the newly constituted 30 districts, increases its alignment.[8]

Since the HSSP I was in turn aligned with the Economic Development and Poverty Reduction Strategy for Rwanda (EDPRS) the HSS proposal can be seen to be aligned with the EDPRS too. However, the poverty focus of the HSS proposal is not apparent, and we feel that it might have been strengthened or highlighted in various ways, such as focusing the HSS financial support on weaker or poorer district or sub-district areas where poverty levels are higher and where MCH indicators are worse. But this was perhaps not technically feasible at the time of design when capacity of the newly created district health administrations was limited, so this is not so much a criticism as a suggestion for the future.

[8] To visualise the integration of the GAVI HSS with the district plans one can use the District Health Systems Strengthening Framework and a sample of Implementation Plans prepared by districts during 2008 (see MOH2008 c, d and e in list of documents reviewed). This can be seen as a more advanced and elaborate approach than the one that was used in 2006 during the GAVI HSS needs assessment. The evaluation team has reviewed a sample of district implementation plans for 2008 and can confirm that the GAVI HSS inputs are fully aligned with these even if they are not always visibly mentioned in the district plan as “GAVI” inputs.

Table 5 Evolution of Poverty Levels in Rwanda

Year	Rural	Urban	HCI average
1990	50.3%	16.8%	47.5%
1994	82.4%	27.5%	77.8%
1995	76.6%	25.5%	72.4%
1999	69.3%	23.1%	65.4%
2006	62.5%	23.3%	56.9%

Source: RoR 2002a: 14, EICV2006 Preliminary results

4.2.2 Alignment with budget and reporting cycles

The GAVI HSS annual planning and reporting mechanisms are not aligned to the Rwanda ones in terms of timing and format of reporting. More importantly perhaps, the APR reports do not provide the intended information because there is no provision for the quarterly or annual district plans to be reflected in the APR report. If GAVI was to be aligned as other health partners are attempting to do it might participate at the Joint Annual Health Sector Reviews where a lot of progress information is presented. It might also be part of regular releases of information including mid-term reviews of the HSSP, presentations of other reports linked to activity in districts, etcetera, but this would require either country presence of the GAVI or at least of a modified IRC. The current IRC review model does not have the capacity, time or local knowledge for it to fulfil its role in relation to the APR.

In terms of alignment with budget and financial management procedures, the GAVI HSS money is “on plan” and features in instruments such as the Medium Term Expenditure Framework (MTEF) for health or the Joint Annual Work Plan (JAWP) depicting government and donor resources. It is not as such “on budget” as the budget only includes government funds and Sector Budget Support allocations.

The timing of the APR is also not in line with Rwanda´s fiscal year (FY). Several respondents emphasised the importance of allowing Rwanda to report to GAVI according to its FY, particularly now that Rwanda will adopt the July-June FY from July 2009, in line with the rest of the East African community. This would require a change in the dates for the Rwanda APR submission. Rwanda is also unable to deliver the audit reports for the previous financial year on time for the APR as this currently coincides with the time when the audit report is being submitted to Parliament. Finally, there is need to clarify whether the financial

information to be delivered in the APR reports refers just to disbursements to districts - as in the APR reports this year and last - or whether some evidence should be provided on the use of funds. This need not be a cumbersome reporting process: Rwanda might simply provide some information of absorptive capacity in districts for the previous year, either overall or in a sample of districts.

4.3 Is GAVI HSS Harmonised?

Several issues touching on harmonisation of planning, reporting and financing procedures have already been discussed in previous sections. In general, the GAVI is not very harmonised with the SWAp arrangements that apply to other donors. If the EPI Directorate is to remain responsible for managing the HSS funds, a possible way to strengthen harmonisation might be to ensure that the ICC formally reports (at least on HSS matters) through the HSCG. This would increase the chances of GAVI HSS funds becoming more integrated with similar funds being provided by other donors.

4.4 Is GAVI HSS funding predictable?

In as much as GAVI disbursed its first tranche of funds soon after proposal approval and then disbursed the second tranche (to cover for the 2008 period) without awaiting the APR process (which would have affected HSS grant implementation negatively) GAVI HSS funding has been quite predictable. Predictability of GAVI HSS funding was considered a positive feature of the HSS grants.

4.5 Is GAVI HSS Results Oriented?

One of the reasons why perceived predictability of HSS funds is high among respondents in Rwanda may be that they assume that the HSS grant is achieving the expected results and that therefore funds will continue to flow in. Since the Rwanda HSS proposal included clear activities and result indicators and has submitted APR reports that have been accepted by the GAVI Secretariat then this must mean surely that the grant is achieving those results. However, the weaknesses of both the APR model and of the HMIS in the MOH do not permit us or anyone else to know whether those results are actually being achieved. The reality is that we do not really know much about either the use or the effectiveness of HSS funding in Rwanda. There are various important things that we do not know about:

- Is HSS money transferred to districts actually being used, for the right purposes and resulting in more or better services?
- What has been the performance of the 30 districts in the absorptive capacity of health funds or in the undertaking of the expected HSS activities?

- What has been the progress on the six results indicators included in the proposal, only 3 of which have been reported on?

In Rwanda, the HSS grant is injecting $0.20 per person per year, which is a very respectable amount given the scarcity of government funding in such a poor country. Partly because of this, we recommend a much stronger involvement of the Department of Planning and Finance in overseeing whether and how the HSS funds are resulting in more or better services.

Problems in demonstrating performance and results orientation of the HSS grants begin at the district level. For example, one of the main barriers for improved MCH and Immunisation services is the difficulty for district authorities to estimate their resource envelope and to allocate resources according to need when most donor resources are highly earmarked and often unpredictable. All these funds incur high transaction costs to the district, although in the case of the GAVI, transaction costs are more moderate because HSS funding is indistinguishable from the remaining GAVI/EPI funding. The positive aspect of this is that GAVI HSS is not imposing additional reporting costs to the districts, but the linked negative consequence is that it becomes extremely difficult to report on performance of the GAVI HSS funds except in terms of immunisation coverage. Whether more supervision takes place or more training or incentives are being delivered is not known. Some of this is reported in the annual reports prepared by districts but the EPI directorate does not have the time or the staff capacity to search for HSS related information within a large number of district reports.

4.6 Is GAVI HSS accountable, inclusive and collaborative?

The HSS proposal is fully owned by the MOH but its accountability to the Department of Planning and Finance or to the HSCG has been found to be weak, as discussed elsewhere. There is hardly any reporting on implementation of HSS in the context of the HSCG (since there are no formal reporting channels from ICC to the HSCG) [9].

We feel that national accountability of the GAVI funds in general and of the HSS funds in particular is weak. We also think that assessing whether HSS funds are additional and used as per plan would require more sophisticated methods for tracking expenditure in districts

[9] Several members of the HSCG confirmed that there had not been any sessions discussing or reporting progress with any of the GAVI grants –including the HSS grants- in the context of the HSCG. One f its members stated: *I am surprised to read (*in the HSS proposal p.25*) that" the HSCG will approve the disbursal of funds…" something that has never been done, and that "the financial reports on activities should be also presented to the HSCG" which has also never been done.*

than are currently in place. In sum, additionality cannot be demonstrated given limited information and weak accountability mechanisms. One health partner who sits in the HSCG stated that "*while excellent immunisation coverage is consistently reported in the context of GAVI work there is hardly any discussion in the HSCG or elsewhere about the unit costs of immunisation and their longer term financing implications linked to, for example, the introduction of new vaccines*" (personal communication from a member of the HSCG).

Accountability could be further compromised in a context where little if any external data quality assurance (DQA) is being routinely performed on EPI (and therefore also) HSS information provided by the EPI Directorate[10]. This role of verifying the quality and reliability of data originating in districts is a big issue in itself and the EPI cannot possibly take up this additional responsibility which is totally outside its remit. EPI and the ICC regularly (monthly we were told) engage in data quality self assessment meetings, but these focus on immunisation, not HSS outputs or activities.

To strengthen national accountability of GAVI and GAVI HSS funds we have recommended elsewhere in this report a formal means of ICC reporting to the HSCG on both EPI as well as HSS matters. While the main purpose of such a measure would be to increase the accountability of the ICC to the HSCG it might also serve to increase the visibility of GAVI HSS funding among other donors in important areas such as the provision of cash incentives to staff.[11] The ICC might like to consider the model used by the Country Coordination Mechanism (CCM) responsible for implementation of the Global Fund grants - including a large $30+ million HSS grant - as an example of improved accountability to national structures. The CCM is de facto a Technical Working Group that reports to the HSCG, while the same is not the case for the ICC. In any case, whether the ICC is the right structure for reporting on progress linked to the HSS grants is doubtful, since on top of its lack of human capacity issues the ICC is primarily designed to discuss and report on immunisation related matters, not on HSS.

4.7 Does GAVI HSS have a catalytic effect?

The catalytic effect of GAVI in areas such as immunisation and new vaccines was clearly recognised by all our interlocutors. However, in the specific case of HSS funding such catalytic effect is hard to see or demonstrate, partly because of the accountability and DQA issues discussed earlier, and partly because we lack information suggesting how do district

[10] The last externally assessed DQA on immunisation figures was conducted in 2002. Not specific DQA linked to HSS has been ever conducted.
[11] Several health partners and MOH officers interviewed in this evaluation were not aware that the GAVI is providing HSS funding in addition to traditional funding areas like vaccines.

managers make decisions linked to the allocation of HSS funds. If the HSS money is having a catalytic effect it should be possible to see improvements in the service delivery indicators over time, but it is far too early for assessing this point in Rwanda. Also, unless HSS reporting improves it may not be possible to ever demonstrate such catalytic effect.

4.8 GAVI HSS sustainability issues

Section 3.1 briefly describes the main objectives and inputs of the Rwanda GAVI HSS proposal. In terms of assessing sustainability issues we are prepared to take the view that the modest investments in infrastructure, equipment and commodities and the much more sizeable investments in training are all necessary investments in the districts that will have either little or manageable sustainability implications. It is however the $2.1 million investments in performance based incentives at both district hospital and community level that raise sustainability concerns. The concern is justified as the amount going into the PBF scheme represents about 34% of the GAVI HSS grant and because the chances that another health partner or the MOH might take up these investments once the GAVI support ends are slim. In the case of the MOH chances are slim because the government is already making a significant financial effort to contribute to the PBF scheme, which will become even higher when the community based PBF is launched. In the case of the partners it is unclear why any health partner would take up what another "project" has done. In fact, health partners who are already contributing to the PBF scheme expect the same as GAVI; i.e. that other sources will take up their own contributions in future. It therefore looks unlikely that these partners would be prepared to take up the increased PBF costs resulting from the end of GAVI HSS funding.

The evaluation team was surprised that with between 24% (as per our table 3) and 34% (when incentives to hospital staff are included) of the GAVI HSS investments going into PBF, the issues around sustainability received so little attention at the time of project design, during the proposal clarification stage or at start up. We were also surprised to verify that none of the three Sector Budget Support partners that we met seemed to be aware that the GAVI is funding performance based incentives. Nor could we find these GAVI HSS inputs reflected in the PBF sections of the JAWP.

It is for all these reasons that we recommend the GAVI and the MOH to look into sustainability of PBF funding post GAVI HSS, and why we also recommend the GAVI not to engage into payment of performance incentives in future without a deeper sustainability assessment that includes a formal discussion with key health sector partners and a more

rigorous assessment of how these performance bonuses will be eventually paid and accounted for.

4.9 Does HSS funding help improved equity

The equity focus of the Rwanda HSS proposal is doubtful if we interpret equity as assigning resources on the basis of need. GAVI HSS funds provide the same level of funding to all the districts and are earmarked to the same inputs. If equity considerations are important to HSS then one might consider the possibility of placing HSS funds within existing Sector Budget Support mechanisms in a future HSS grant (as Belgium, Germany, Switzerland or the United Kingdom are already doing). This approach would be much more systems strengthening in the medium term, but it must be admitted that it was not possible at the time of HSS design.

Annex 1 List of people met

Day & Date	Time	Person to meet	Institution
Tuesday 12th May	9 am 5.30 pm	Leonard Karasi Dr Agnes Binagwaho	Co-author study Permanent Secretary MOH
Wednesday 13th May	11 am	Jean Gakwaya	DFID Senior Program Officer
	5 pm	Dr Fidele Ngabo	Director EPI MOH
Thursday 14th May	8 am	Elisabeth Girrbach	Coordinator Health GTZ
	9.30	Michel Gatete	Partners Coordination, MOH
	3pm	Dr Abdoulie D JACK Dr Malifa M Balde	WR, WHO. MO EPI CSR, WHO,
Friday 15th May 09	9 am	Fidele Karangwa	Director of Finance, MOH
	10 am	Dr Jean Nkurunziza	M&E, MOH
	11 am	Dr Paulin Basinga	School of Public Health
Saturday 16th May		Report Writing	
Sunday 17th May		Report Writing	
Monday 18th May	8.30 am	Dr Celse Rugambwa	NPO EPI WHO
	11 am -	Remo Meloni & Jean Marie Tromme	Belgium Technical Cooperation -BTC
	2.30 pm	Diane Muhongaire,	WHO –sits in HSCG
	4 pm	Friday Nwaigwe Denis Muhoza	Chief H&N, UNICEF Health Officer, UNICEF
Tuesday	9.00	Report writing	
	15.00	Cathy Mugendi	Community Health Desk – Community PBF
Wednesday	15.00	Kevin Bellis	Consultant DFID
Thursday		Report writing	

Annex 2 List of Documents reviewed

EPOS 2008. Rwanda – Support for Joint Annual Work Plan (JAWO 2008) – Health sector Rwanda. Mission Report November 2007-April 2008. EPOS Health Consultants.

GAVI 2007. Rwanda HSS GAVI Pre-Review (2007). GAVI Alliance Secretariat, 2007.

IRC 2008. IRC report Rwanda for the reporting period 2007. September 2008.

HSCG 2008. Review of the Capacity Development Pooled Fund. January-march 2008. Rwanda HSCG. Author uncknown.

MOH 2005. Rwanda Health Sector Strategic Plan I 2005-2009. Ministry of Health, Republic of Rwanda, 2005.

MOH 2007. Memorandum of Understanding between the Ministry of Health and Health Sector Development Partners. Ministry of Health, Government of Rwanda, 2007.

MOH 2008a. Evaluation Report of the Mid term Review of the HSSP I 2005-2009 by the external evaluation team 23 June-7 July. Kigali, 24th July 2008.

MOH 2008b. Rwanda District Health System Strengthening Framework. And Plans. Powerpoint Presentation to Senior managers and HSCG meeting. 22 September 2008.

MOH 2008c. The Rwanda District Health System Strengthening Framework. Annex A - Best practices for district planning. Kigali, July 2008.

MOH 2008d. The Rwanda District Health System Strengthening Framework. Annex B – Methodology. Kigali, July 2008.

MOH 2008e. The Rwanda District Health System Strengthening Framework. Annex C – Implementation Plan – Bugesera District. Kigali, July 2008.

MOH 2009a. Health Sector Strategic Plan II 2009-2012. Ministry of Health, Government of Rwanda, July 2009.

MOH 2009b. Rwanda - Health Sector Performance Review 2008. MOH, March 2009

RSPA 2008. 2007 Rwanda Service Provision Assessment Survey. Policy Briefs on: Child health; Maternal health; HIV/AIDS; malaria; Family Planning. USAID and Government of Rwanda, 2008.

Smithson & Martinez 2006. Addressing Health MDGs in Rwanda - Progress, Gaps, Challenges and Opportunities. DFID Health Resource Centre. February 2006.

Powerpoint presentations at the Joint Health Sector Review meeting November 2008.

- Health Sector MTEF 2008- 2010, by Mr André Habimana
- Governance and Coordination: SWAp and SBS Implementation, by Dick De Clercq, Elisabet Girrbach & Michel Gatete.
- Infrastructures, équipements et maintenance et concept de la maintenance, by Martin Manzi
- The current status of Human Resources for Health in Rwanda, by Vivens Kalinganire & Diane Gashumba
- Health Financing in Rwanda, by Claude Sekarabaga
- Health Sector Strategic Plan II 2009-2012, by Claude Sekarabaga
- Actions Taken following JHSR 2007, by Agnes Binagwaho, Permanent Secretary MOH.
- Millennium Development Goals 4&5 – Maternal and Child Health, by Fidele Ngabo
- HIV/AIDS, TB and Malaria, MDG 6, by TRAC *Plus*, NRL , USG, WHO, UNAIDS

- MDG 4 & 5 – Report from the District of Huye, by Petronille Uwizeye
- Rwanda - Budget Execution 2008. Presentation by Fidele Karangwa, MOH Director of Finance at the March 2009 Joint Health Sector Review meeting.

Annex 3 Summary GAVI HSS Evaluation Approach

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

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

Il existe cinq principaux objectifs et domaines d'évaluation :

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

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

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

Annex 4 Typology of areas for HSS support

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