GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Sri Lanka Desk Study

Final Version – August 2009

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Submitted by

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Acronyms and abbreviations

APR	Annual Progress Report
DDG (BES)	Deputy Director General (Biomedical Engineering Services)
DDG (ET&R)	Deputy Director General (Education, Training and Research)
DDG (P)	Deputy Director General (Planning)
DDG (PHS)	Deputy Director General (Public Health Services)
DGHS	Director General of Health Services
FHB	Family Health Bureau (of MOHN)
HMP	Health Master Plan 2007-2011
HMPISC	Health Master Plan Implementation Steering Committee (of NHDC)
MDPU	Management Development and Planning Unit
MOH	Medical Officer of Health
MOHN	Ministry of Healthcare and Nutrition
NHDC	National Health Development Committee
PD	Provincial Director
RDHS	Regional Director of Health Services (actually for district)

Summary of key findings

The GAVI HSS programme is focused on reducing disparities in services delivery between 10 disadvantaged districts and the national norms, mainly in MCH-related services and in strengthening primary health care across the board. Sri Lanka already achieves extremely high immunization coverage rates. The GAVI HSS funded programme is country driven, based on well-understood needs and solutions, and aims to achieve practical results in:

- Training and increasing PHC staff in the districts concerned;
- providing some basic infrastructure improvements, mainly in transport to increase service delivery and supervision;
- improving the monitoring and supervision of MCH service providers by middle level managers.

The programme appears sensible, relevant and achievable, and is likely to help strengthen primary care delivery. Indicators are clearly related to objectives, and are mostly within existing data collection and analysis mechanisms. Financial and other mechanisms also seem to be well integrated within prevailing government procedures and mechanisms.

Some issues that arise from this desk evaluation include the following:

- The APR covering start up and implementation during the first year (2008) had not been submitted to GAVI by June 2009 and this desk study is not able to assess progress being made in implementation
- there is no mention of how the programme will relate to the non-state sector (it is known that the private sector has been growing and is now significant in Sri Lanka)

Although from the proposal document, the process appears to have been very centrally driven with little active participation of district level staff and consumers, or with the private sector, the ministry claims wide participation of district staff through planning workshops and the normal monthly meetings.

1 Scope and methodology

The GAVI HSS Evaluation 2009 conducted 11 in-depth case studies in the following GAVI HSS recipient countries, Burundi, Cambodia, Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were subject to desk studies that did not involve country visits but were limited to a review of available documentation combined with email/phone interviews. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

The overall evaluation methodology (framework, key questions, study components, guidelines for data collection, sampling method, etcetera) is discussed in the main body of the evaluation report and is not reproduced here.

2. The Sri Lanka GAVI HSS proposal – inputs, process and progress

This section describes the process of design, application, progress and review. Section 3 evaluates the process in practice against GAVI principles.

Contextual factors

High-level coordination of the sector is undertaken by the National Health Development Committee (NHDC). Following the launching of the Health Master Plan (HMP) 2007 – 2016 in February 2007, the NHDC set up a Health Master Plan Implementation Steering Committee (HMPISC) to guide and monitor implementation under five strategic objectives:

1. To ensure the delivery of comprehensive health services, which reduce the disease, burden and promote health;
2. To empower communities (including households) towards more active participation in maintaining their health;
3. To improve the management of human resources for health;
4. To improve health financing, resource allocation and utilisation; and
5. To strengthen stewardship and management functions of the health system.

The HMPISC includes the Secretary of Health (Chair), Additional Secretaries, Deputy Director Generals, all Provincial Directors, Ministry of Finance and Planning, Finance Commission, and Development Partners. The GAVI HSS support was identified as complementing strategic Objective number 5 and the HMPISC was designated as the HSCC body to coordinate and monitor the HSS support.

2.1 HSS proposal design

Who was involved, how and in what time periods?

The process was led by the Chief Planning Officer of the Management Development and Planning Unit (MDPU) of the Ministry of Healthcare and Nutrition, with policy guidance provided by the Hon Health Minster, the Secretary of Health and the Director General Health Services. It was supported by the Deputy Director General, Public Health Services (DDG(PHS)), Officers from the Family Health Bureau, the

Epidemiology Unit and the National Institute of Health Sciences (who are responsible for the national scale implementation of the maternal and child health services, immunization programmes and development of the health workforce respectively), and officials of the WHO Country Office, UNICEF, UNFPA, JICA and the World Bank. The proposal makes no mention of consultation at district level with providers or consumers, although it is thought that districts do have plans and these may have been taken into account.

What technical support was provided?

The Management Development and Planning Unit (MDPU) of the Ministry of Healthcare and Nutrition led the design of the programme and drafting of the application. UNICEF, UNFPA, JICA, World Bank and WHO Regional and Country Offices were proactively involved in providing technical assistance throughout the planning process.

What components were identified?

GAVI HSS support was seen as an opportunity to correct some deficiencies in service delivery through selective health systems strengthening. The proposal covers developing the health workforce to deliver PHC services more efficiently and effectively, putting more effective monitoring and supervisory systems in place, and filling gaps in selected PHC delivery infrastructure. The entire proposal targets underserved locations.

What objectives, activities, indicators and targets were specified?

The goal of the GAVI HSS proposal is to accelerate the reduction of MCH related morbidity and mortality in underserved areas, through improvement of coverage and quality of MCH services. The specific objectives are:

1. To increase Primary Health Care staff and to achieve the correct skill mix in 10 underserved districts to reach national norms by 2012.
2. To ensure availability of basic infrastructure and logistics to meet the national standards in 10 underserved districts for the delivery of maternal and child health services by 2012
3. To ensure adequate monitoring and supervision of MCH services is carried out in 10 underserved districts by middle-level facility managers, by 2012.

The expected results are:

1. To overcome shortages (including geographical imbalances) of PHC workers especially in conflict affected districts and the districts that are underserved;
2. to improve the quality of the basic training of PHC workers;
3. to expose PHC workers to needs-based in-service training through a 'Systematic Continuing Educational Programme';
4. to improve the management capacity of supervisors and middle-level managers, in order to oversee and ensure provision of high quality MCH services by all PHC staff;
5. to make basic infrastructure and facilities available at selected geographical locations (in conflict affected and under privileged areas) for delivery of maternal and child health services.

The project period is for the five years from 2008 to 2012, and the proposed budget is US$ 4,595,715. A budget of US$4,505,000 was approved by GAVI in November 2007.

Activities and output targets

Objectives & Activities	Expected outputs	Discussion	Responsible party
Objective 1. **To increase Primary Health Care staff in correct skill mix in 10 underserved districts to reach national norms by 2012.**	Staff trained on MCH best practices in place in 10 underserved districts, based on: 1 PHM/1500 pop.; 1 MOH /30,000 pop.; 1 PHI/10,000 pop.	HMP pp.6-6 to 6-9: acute shortages of paramedics and other PHC providers hampers delivery of MCH and immunization services, which is echoed in the cMYP assessment from 2007.	DDG/P DDG/ET&R
1.1 Develop HR plan for underserved areas which will be an input for national HR development plan.	National HR plan completed by 2008 and implemented by 2012.	SFHD notes the MOHN role for HR development is to be expanded from recruitment, distribution and training to include policy/planning, HR development and management, collection and analysis of HR data and coordinating a strategic approach to HR development across other ministries and institutions, including academic and training centres.	DDG/ET&R DDG/P
1.2 Improve the facilities for PHC staff training at six training schools/facilities (Jaffna, Baticaloa, Badulla, Kandy, Rathnapura, Galle).	All six training facilities fully upgraded by 2012.	Jaffna, Baticaloa, and Badulla were selected because they are the only ones located in the 10 selected districts, and the additional 3 were required to ensure sufficient numbers of staff are trained to meet needs for all 10 districts.	DDG/ET&R DDG/P
1.3 Recruit 600 qualified candidates for training from the underserved areas starting from 2008.	200 candidates enrolled annually in revised training program, starting in 2008.	Candidates will be recruited form 10 districts, to increase the likelihood of retention of staff.	DDG/PHS DDG/ET&R

Objectives & Activities	Expected outputs	Discussion	Responsible party
1.4 Annual Training of 300 PHC staff at 6 upgraded training schools.	300 PHC staff trained at 6 upgraded schools per year	This is to help close the HR gap currently constraining sustainable provision of MCH and immunization services in the 10 districts.	DDG/ET&R D/NIHS
1.5 Posting of trained PHC staff of correct skill mix to 10 underserved districts starting from year 2011.	300 newly trained staff posted annually commencing in 2010, in the 10 underserved districts.	This is to help close the HR gap currently constraining sustainable provision of MCH and immunization services in the 10 districts.	DDG/PHS
1.6 Conduct in-service training programmes for all PHC workers of underserved districts.	20% of PHC staff in each of 10 districts receive revised training each year, starting in 2008	To upgrade knowledge and skills to cope with new challenges and introduction of new services and interventions(e.g. pentavalent DTP-HiB-HepB)	DDG/ET&R
Objective 2. **To ensure availability of basic infrastructure and logistics to meet the national standards at 10 underserved districts for delivery of maternal and child health services by 2012**	All 10 districts will have sufficient basic infrastructure in place and functioning, to provide the full range of MCH services, by 2012.	HMP p6-8 to 6-9:This will supplement on-going government effort to upgrade facilities under the Health-Reform Programme in the North-East Provinces, as well as some single projects having donor support (e.g. from MSF). Part of the effort will support strengthening sentinel sites for selected diseases (e.g. pneumococcal disease) as well as the surveillance network in these 10 districts.	DDG/P
2.1 Improve the existing infrastructure facilities at MCH clinic centres in underserved districts.	Ensure all facilities have access to basic water, sanitation and power supplies.	HMP p6-1: areas affected by conflict lack infrastructures, staff and equipment, especially at the primary heath care level, to provide adequate health services for the resident population as well a large numbers of Internally Displaced Persons.	D/FHB

2.2 Supply basic MCH equipment packages to all MCH clinics in 10 underserved districts.	By 2012, all facilities will have the minimum package of equipment required for providing MCH services, which comprise BP cuffs, scales, exam beds, health registers.	Maintenance costs for all equipment will be provided for in the regular budget.	DDG/BES
2.3 Supply 10 double cabs for MOH divisions in 10 underserved districts to ensure effective implementation of PHC services.	One double cab to each of 10 districts, by 2012	Survey carried out in 2007 by Family Health Bureau noted scarcity of vehicles many underserved areas in these 10 districts, and that all districts needed strengthened systems for vaccine and other MCH supplies distribution and logistics. Maintenance costs for all vehicles are provided for in the regular budget	DDG/BES
2.4 Supply 500 mopeds for Public Health Midwives in 10 underserved districts for efficient delivery of PHC services.	By 2010, each district will receive 50 mopeds, for use in most underserved areas.	This is to ensure outreach and mobile team activities can be carried out. Maintenance costs for all vehicles are provided for in the regular budget	DDG/BES
2.5 Supply 20 scooters for supervisory staff covering underserved districts.	By end of 2008, all 10 districts will receive 2 scooters.	This is to ensure supervisory visits are carried out regularly by public health nurse sisters, whose duty is to carry out supervisory activities. Maintenance costs for all vehicles are provided for in the regular budget.	DDG/BES
2.6 Supply 100 motor bikes for Public Health Inspectors in underserved districts for efficient immunization coverage.	By 2011, each of 10 districts will receive 10 motorbikes.	Public Health Inspectors are responsible for environmental safety, food safety and carrying out School medical inspections and School Immunization Activities. Maintenance costs for all vehicles are provided for in the regular budget.	

2.7 Supply 2 double cabs (to FHB and Epidemiology unit) for strengthening of central support to MCH services at underserved districts.	By 2010, the FHB & EPI. units receive both double cabs.	FHB and Epidemiology Unit provide all technical guidance to PHC staff at the district and divisional levels, to carry out all MCH services. Maintenance costs for all vehicles are provided for in the regular budget.	DDG/BES
Objective 3. **To ensure regular monitoring and supervision of MCH services carried out at 10 underserved districts by the middle level facility managers, by 2012**	Increase MCH coverage (which includes immunization) among all target age groups living in underserved areas.	As part of the MOHN Quality Assurance programme, clinical accountability and development of peer group reviews will be introduced to help assess and improve services quality. To ensure sustainability, professional organizations, medical faculties and services providers will be involved in developing supervisory systems and revising pre and in-service training, to support the Quality Assurance Strategy.	DDG/P
3.1 Quarterly district management review meetings held in all 10 districts.	Regional Deputy Director of Health Services convenes quarterly meetings to review quality of MCH services and divisional staff performance under the oversight of each Divisional head, in all 10 districts by 2009.	This is to support on-going efforts to make management more responsive to changing conditions and to use data on performance to guide micro-planning.	DDG/P
3.2 Conduct training programs for supervising staff on monitoring and supervision in a devolved health system.	2000 PHC workers in 10 target districts receive training on supervision.	The cMYP assessment considers improved EPI Surveillance through provision of training (and research) as an essential component of in-service training for all PHC staff.	D/training

3.3 Develop performance appraisal tool to assess MCH skills of, and reporting by, PHC staff.	PA tool developed and piloted in 2 districts by 2009.	This supports the MOHN funded policy to introduce a system of individual and institutional performance management. Incentives and rewards are to be based upon individual performance.	RDHS
3.4 Train district-level managers and supervisors on PA tool.	PHC supervisors and managers in all 10 districts receive training on tool by 2012.	Supports the system of individual performance management. Incentives and rewards are to be based upon individual performance.	
3.5 Train PHC staff in 10 districts (approx. 2000 staff) on best practices for AEFI surveillance.	% of districts completing monthly AEFI surveillance report on time.	To improve detailed investigation of selected AEFIs, filling a gap caused by lack of resources at the divisional (sub-district) level.	PD
3.6 Review the quality and efficiency of existing management information system on MCH including EPI.	A national Data Quality Audit conducted to assess HMIS for MCH including EPI) by 2010.	A national Data Quality Audit is being planned to asses national and district quality of data levels.	DDG/P
3.7 Staff performance appraisal will include assessing the completion and timely submission of monthly reports from MOHs to divisions and quarterly reports from Divisions to central level.	100% of reports submitted on time, with at least 90% completion, by 2009, and to be evaluated in 2010 on desirability of national scale-up.	This supports the MOHN funded policy to introduce a system of individual and institutional performance management. Institutional performance management will require all institutions and programmes to issue Annual Reports on progress, based on guidelines distributed by the Management Development and Planning Unit of the MOHN.	DDG/P

How will monitoring and evaluation be undertaken?

Sri Lanka has well-functioning data collection, and the GAVI HSS project it is not expected to create any new or parallel monitoring and evaluation mechanisms. All outcome indicators are currently monitored under the Health Master Plan 2007-2016, but some of the proposed output indicators will require improved data collection practices, and this is one of the components of the training received by MCH providers under the GAVI HSS proposal.

Also, the GAVI HSS grant will be used to strengthen the field-based monitoring, supervision and evaluation mechanisms, and link these to the Performance Appraisal System, thus helping to motivate field workers.

Impact and outcome indicators

Indicator	Baseline 2005	Target for 2012
1. Under 5 mortality rate [impact]	16.0 / 1000 Live Births	2012 target:11.0 /1000 (2015 target: 8.0 / 1000)
2. Infant Mortality Rate [impact]	11.0/ 1000 Live Births	2012 target: 9.0 / 1000 (2015 target: 7.0 / 1000 LB)
3. National DTP3 coverage (%)[outcome]	96%	99%
4. Number / % of districts achieving ≥ 80% DTP3 coverage (with assessing trends in underserved districts) [outcome]	100%	100%

Output indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value	Source	Date of Baseline	Target	Target Date
Proportion of births attended by skilled PHC staff in 10 underserved districts.	Births attended by skilled PHC staff	Total births (per district)	HMIS	98%	FHB, MOHN	2006	100%	2012
% of children 1-5 utilizing PHC services at MCH centres in underserved divisions.	Children ages 1-5 utilizing PHC services at MCH centres	Total children ages 1-5	HMIS	< 68%	FHB, MOHN	2006	>95%	2012
% of mothers receiving post natal care of accepted levels at home within first 10 days after delivery in the underserved areas.	Mothers receiving post natal care visit at home within first 10 days	Total mothers post-partum	HMIS	<67%	FHB, MOHN	2006	>95%	2012
Objective 1: Staff trained on MCH best practices in place in 10 districts, based	Staff trained on MCH best practices	N/A	Quarterly district reports	N/A	Regional Director of Health, who sends them to	2006	100%	2012

on: 1 PHM/1500 pop.; 1 MOH /30,000 pop.; 1 PHI/10,000 pop.					Family Health Bureau,			
Objective 2: All 10 districts will have sufficient basic infrastructure in place and functioning, to provide the full range of MCH services, by 2012.	Districts with sufficient basic infrastructure	10	Quarterly district reports	N/A	Regional Director of Health, who sends them to Family Health Bureau,	2006	100%	2012
Objective 3: Increase MCH coverage (which includes immunization) among all target age groups in underserved areas. [NB: aTd coverage used as proxy]	No.# of children who receive a single dose of aTd	Total children enrolled in grade 7	HMIS	73%	Epidemiology Unit, MOHNN	2006	>95%	2012

The GAVI HSS proposal also includes a small amount for some operational research although this appears to mean mostly surveys of consumer satisfaction to be undertaken later during implementation.

2.2 HSS application, review and approval

What country coordination and approval mechanisms were used?

The MDPU was assisted by the WHO Country Office and the GAVI HSS WHO Regional Focal Point in New Delhi. The first draft of the application was circulated to the planning team members and their comments incorporated. The second draft was circulated for comments among representatives of development partners, including WHO, UNICEF, UNFPA, World Bank, ADB, and JICA and among the members of HMPISC. The draft proposal was sent to WHO SEARO for comments and technical assistance.

After approval by HMPISC, the application was endorsed by the Secretary, Ministry of Healthcare and Nutrition and the Director General National Planning Department of the Ministry of Finance.

2.3 HSS start up measures

Financial arrangements

GAVI HSS funds will be entered into the external account of the national health budget administered by the MOF. Based on annual budget estimates submitted, MOF will release the relevant funds budgeted under the line ministry to the Director General Health Services of the Ministry of Healthcare and Nutrition. Funds budgeted under the Provincial Ministries will be released to the Finance Commission (under the MOF) and channelled to Provincial Councils which in turn will channel them to Provincial Health Ministries against the annual plans already agreed under GAVI HSS. The Provincial Health Ministries in turn will channel funds to Deputy Provincial Directors of Health Services for implementation.

The Management Development Planning Unit of the Ministry of Health will develop annual Implementation/operational plans, with the active involvement of provincial and district authorities. Activities will be budgeted, responsibility for implementation will be identified, and based on that responsibility, the budget lines will be reflected either in the line ministry budget or Provincial Ministry budgets. Government regulations require these budgets to have the approval of the Department of National Planning (for the line ministry) or the Finance Commission (for the Provincial Ministries).

Audit is undertaken by the internal audit unit of the MOHN which functions independently and reports to the Secretary of Health as the Chief Auditing Officer. In addition, the Auditor

General's Department carries out external audits independently from the MOHN and reports to the MOF and Parliament. This covers both government and donor funds.

Management and reporting arrangements

GAVI HSS implementation is managed by the Director of Planning under the Deputy Director General (Planning) of the MOHN. Implementation is overseen by the HMPISC, and the Chair of the HMPISC (the Director General of Health) reports progress quarterly to the NHDC which itself reports to the Minister of Health. Like all other major externally funded programmes, implementation will use normal government procedures, so that NHDC is able to ensure coordination between these. HMPISC members include representatives from MOF, WHO, UNICEF and UNFPA.

2.4 Annual progress reporting (APR)

Reports submitted – dates

No APR that covers HSS is yet available (as at June 2009). GAVI documents indicate that the GAVI HSS grant of US$4.5 million was approved in November 2007 and that US$1.9 million was disbursed by the end of January 2009. Sri Lanka reports that the first transfer was for US$887,000 and was received in May 2009. Sri Lanka aims to submit an APR covering 2008 later in 2009 but that because of the conflict situation and some changes in the planning unit, there were not many activities undertaken in 2008, and the submission will mainly cover details on expenditure.

2.5 HSS implementation progress

Detectable changes in outputs and outcomes

No information has been available to this desk study.

2.6 End of HSS assessment

Since no information is available on progress in implementation to date, little can be said about the likelihood of the programme achieving its objectives. However, the Sri Lanka GAVI HSS programme appears modestly sensible in its aims and well within the capacity of the MOHN to implement. Immunisation rates and birth attendance rates are already very high in Sri Lanka, reflecting decades of sector development and the high priority that successive governments have placed on health care. Whilst national rates are unlikely to be significantly improved by GAVI HSS, it will be important to try to detect improvements in the

under-performing districts, a challenge that will be made much more difficult after the devastating setbacks of civil disturbances.

2.7 Support systems for GAVI HSS

This has been covered under design and application steps in the GAVI HSS process outlined above. Sri Lanka appears to have consulted widely with in-country technical agencies and with the WHO regional office itself supported by GAVI Secretariat in holding the regional workshop. Although the Management Development and Planning Unit (MDPU) of the Ministry of Healthcare and Nutrition (which led the proposal design) is responsible for district health systems as well as national, and the HMPISC membership includes all Provincial Directors, there is no mention in the application of consultation at the district level. Nor is there mention of involvement of the non-state sector although this is substantial in Sri Lanka.

3. Assessment against GAVI HSS principles

3.1 Country driven

There appears little doubt that the GAVI HSS proposal was country driven and responded to established weaknesses in services delivery in disadvantaged districts. It does appear, however, to have been centrally driven with relatively little substantive input from districts or the non-state sector.

3.2 Aligned with national plans and processes

i. With broader development policies and sector goals

The GAVI HSS proposal appears to be aligned with the relevant national plan (Health Master Plan 2007-2016) and the IRC report states that it is also aligned with the cMYP 2007-2011. Its focus on underperforming districts is aimed at reducing inequitable provision and consumption of MCH and related services. Its objectives of increasing staff in those areas, of improving supervision and monitoring of front line staff, and of improving basic infrastructure, will strengthen primary care as a whole.

ii. With budget and reporting mechanisms and cycles, and M&E Finance

Sri Lanka states that it will use existing government procedures for receiving, disbursing and accounting for external funds. GAVI funds are sent to the MOHN and the DGHS then informs MOF which enters them into the external funds head of the national health budget. Normal channels are then used to get funding from the centre to districts.

iii. M&E data collection, analysis and use

Sri Lanka's systems for monitoring and evaluation of primary health care have been traditionally strong, and efforts have been made in the GAVI HSS programme to employ these and to minimise the needs for additional or special data collection.

Impact and outcome	Data collection	Data analysis	Use of data
1. IMR (base line 11.0 / 1000 LB, target 9.0 / 1000 LB by 2012)	Divisional level: Public Health Midwife [HMIS], Births & Deaths registers District level: Medical Officer of Maternal and Child Health [HMIS]	Divisional level: Medical Officer of Health District level: Medical Officer of Maternal and Child Health National level by FHB and Registrar Generals Department	Divisional level review and micro-planning District level review: to guide objectives of supervisory visits; to inform Performance Appraisals National level review: to monitor progress towards MDGs and HMP targets for 2015
2. DPT3 immunization coverage in under served areas (target >99%, by 2012).	Divisional level: Public Health Midwife [HMIS] District level: Regional Epidemiologist [HMIS]	Divisional level: Medical Officer of Health District level: Regional Epidemiologist [HMIS] National level by Epidemiology Unit	As above
3. Under 5 mortality rate (base line 16.0 / 1000, target 11.0 /1000 by 2012).	Divisional level: Public Health Midwife [HMIS], Births & Deaths registers District level: Medical Officer of Maternal and Child Health [HMIS]	Divisional level: Medical Officer of Health District level: Medical Officer of Maternal and Child Health National level by FHB and Registrar Generals Department	As above
4. % of districts achieving ≥ 80% DTP3 coverage (with assessing trends in underserved districts) [Target 100% 2012]	Divisional level: Public Health Midwife [HMIS] District level: Regional Epidemiologist [HMIS]	Divisional level: Medical Officer of Health District level: Regional Epidemiologist [HMIS] National level by Epidemiology Unit	As above
Output	**Data collection**	**Data analysis**	**Use of data**
1. Proportion of births attended by skilled PHC staff in 100 underserved divisions. (base line 98% in	Divisional level: Public Health Midwife [HMIS] District level: Medical Officer of	Divisional level: Medical Officer of Health District level: Medical Officer of Maternal and	As above

2006, target 100 % in 2012)	Maternal and Child Health [HMIS]	Child Health National level by FHB	
2. Proportion of children under 5 utilizing PHC services at MCH centres in underserved divisions. (base line <68% target >95% by 2012).	Divisional level: Public Health Midwife [HMIS] District level: Medical Officer of Maternal and Child Health [HMIS]	Divisional level: Medical Officer of Health District level: Medical Officer of Maternal and Child Health National level by FHB	As above
3. Proportion of mothers receiving post natal care of accepted levels at home within first 10 days after delivery in the underserved areas. (< 67% base line, target >95% in 2012.	Divisional level: Public Health Midwife [HMIS] District level: Medical Officer of Maternal and Child Health [HMIS]	Divisional level: Medical Officer of Health District level: Medical Officer of Maternal and Child Health National level by FHB	As above

3.3 Harmonised with other funding and support

Although no details are provided in the proposal, it is clear that the MOHN is well aware of the need for harmonisation, and how coordination of externally funded programmes including the World Bank funded Health Sector Development Project, can be achieved through the HMPISC reporting to the NHDC. In fact, because the country has achieved such high levels in key indicators, there are very few development partners working in the country.

3.4 Providing predictable funding

The actual flow of funding is not known and there is no APR as yet to provide information on this.

3.5 Accountable, inclusive and collaborative

Although from the proposal, the process appears to have been very centrally driven with little active participation of district level staff and consumers, or with the private sector, the ministry claims wide participation of districts through planning workshops and the normal monthly meetings.

3.6 Having a catalytic effect

Nothing is known about this yet.

3.7 Results oriented

Sri Lanka submitted a GAVI HSS proposal in April 2007 that the IRC recommended should be changed and re-submitted to show a clearer linkage between the problems identified and the goals, objectives and activities proposed to address them (and because the budget requested was in excess of the formula). The re-submitted proposal now provides clear objectives clearly linked with activities, and measurable output indicators. Outcome targets appear to be based on achieving MDGs rather than on any clear estimate of what may be achievable in practice year by year.

3.8 Sustainable

The GAVI HSS interventions do not appear to involve significant additional recurrent cost implications, although there is no attempt to estimate what these will be in the proposal. The foreign aid component of the health expenditure has fallen from 10% in 1998 to 4.5% in 2002 and Sri Lanka continues to fund health services as a priority for government expenditure.

3.9 Improving equity

The GAVI HSS is focussed on 10 disadvantaged districts aiming to improve coverage and quality of MCH services. There seems little doubt that the districts selected are so disadvantaged.

Annex 1 Documents available

Sri Lanka GAVI HSS application, October 2007

GAVI HSS IRC Proposal Review, November 2007

Annex 2 Telephone conversations

Palitha Abeykoon, WHO Sri Lanka

Dr Sarath Samarage, DDG (Planning), Ministry of Healthcare and Nutrition

Annex 3 Summary GAVI HSS Evaluation Approach

The GAVI Alliance HSS Evaluation Study Approach

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

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

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

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