



GAVI, THE VACCINE ALLIANCE

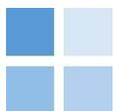
**META-REVIEW OF COUNTRY EVALUATIONS OF GAVI'S HEALTH SYSTEM
STRENGTHENING SUPPORT**

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FINAL REPORT

Submitted by:

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ACRONYMS AND ABBREVIATIONS

Acronym	Full description
APR	Gavi's Annual Progress Report
cMYP	comprehensive Multi-Year Plan
CSO	Civil Society Organisation
DFS	Gavi's Direct financial support
DHO	District Health Officers
EPI	Expanded Programme on Immunization
FCE	Full Country Evaluations (commissioned by Gavi)
FMA	Gavi's Financial Management Assessment
HSCC	Health Sector Coordination Committee
HSS	Health System Strengthening
IHP+	International Health Partnership
IRC	Gavi's Independent Review Committee
MoH	Ministry of Health
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
NVS	New and underused Vaccine Support
OECD DAC	Organization for Economic Cooperation Development Assistance Committee
PBF	Performance-Based Funding
PFA	Partnership Framework Agreement
SCM	Gavi Senior Country Manager
SFA	Strategic Focus Area
ToR	Terms of Reference
WHO	World Health Organization
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

Cambridge Economic Policy Associates (CEPA) has been appointed by Gavi, The Vaccine Alliance (Gavi) to conduct a meta-review of country evaluations of Gavi’s Health System Strengthening (HSS) support. This study has been commissioned on the request of the Gavi Board and Evaluation Advisory Committee to provide increased learning and accountability on HSS grants, as part of an ongoing effort to improve the HSS window.

The meta-review includes an analysis of 14 evaluation reports of country HSS grants approved prior to 2012 and conducted over the period 2013-15¹, and also incorporates triangulation with the main findings on HSS grants from the ongoing Full Country Evaluations (FCE) project and recent Independent Review Committee (IRC) reports. The methodology for this meta-review has been to review all evaluation reports using an “a priori” analytical and coding framework, covering dimensions of relevance and alignment; efficiency and effectiveness; results and impact; and sustainability. Key findings across these four dimensions have been developed based on the synthesis of evidence across the 14 evaluation reports and each finding has then been assessed for robustness (“strong”, “good”, “limited” and “poor”), based on *quality* of evaluation reports and *quantity* of evidence (based on number of evaluation reports stating a particular finding and corroboration with the FCE findings and IRC reports).

The summary of key findings, by robustness rating, is as follows:

Findings with a “strong” or “good” robustness rating

- Country programme management has been poor, primarily on account of weak country capacity coupled with poor planning.
- Gavi’s model of delivery for HSS in terms of guidance and support from the Secretariat and Partners has not functioned effectively across the grant cycle, with most evaluation reports recommending more active guidance and communications from Gavi through a more “hands-on” model.
- Gavi HSS grants have experienced substantial delays in implementation, leading to deviations from programme design.
- Monitoring and reporting systems are not functioning effectively, largely due to lack of clarity of indicator definition, relevance to HSS programming and overall roles and responsibilities design at proposal stage.

¹ Afghanistan, Burkina Faso, Cameroon, Chad, Eritrea, Ethiopia, Ghana, Madagascar, Myanmar, Nepal, Somalia, Sudan, Tajikistan and Yemen.

- Gavi HSS support to countries has been well-aligned with their health sector policies and plans, however weak country planning capacity has implied that several grants have not been designed effectively, thereby somewhat diluting their relevance.
- In terms of adherence with Gavi’s mandate, there has been wide variation in the interpretation of Gavi HSS support, with countries generally being unclear on Gavi’s scope and objectives for the HSS window.
- The proposal development process has been somewhat participatory, although often lacking Civil Society Organisations (CSO), and concerns have been raised on representation and adequate guidance from the Gavi Secretariat and Alliance Partners.
- Whilst reprogramming of country grants has resulted in greater relevance for countries and increased immunisation focus, there is a general lack of understanding of this process at the country level and significant transaction costs have been incurred.

Findings with lower robustness ratings

The evaluation reports indicate that proposed activities have, for the most part, been completed and that some improvements in immunisation and health outcomes have been seen in most countries. However, it is difficult to attribute this to Gavi HSS support with full certainty even if there is emerging evidence that Gavi HSS support does contribute to health system strengthening. The lower level of robustness of these findings indicates the challenges with demonstrating results under Gavi’s HSS approach.

Further, whilst there is some evidence of Gavi HSS activities being sustained or there being potential to sustain after the completion of funding, for the most part, potential for financial sustainability is weak.

Other findings have been in terms of noted issues around the functioning of the country Health Sector Coordination Committee (HSCC) during grant implementation, and weak country financial management capacity and procedures, resulting in low absorption and delayed disbursements.

Recommendations

While Gavi has modified its approach to HSS support over the years (e.g. through the introduction of performance-based funding, the performance framework, joint appraisals, improved application guidelines, ongoing review of Gavi direct financial support, etc.), we note that: (i) majority of findings from the country HSS evaluation reports have been supported by the more recent FCE and IRC reports, thereby indicating that the issues have not been substantially or fully addressed; and (ii) several of the noted interventions have been recently developed/ introduced or are currently in development, and hence it would be important to understand their impact in

circumventing the identified challenges. As such, it is our opinion that while Gavi is presently making some changes, the key issues identified have not, per se, been addressed.

As such, we present the following recommendations relating to the design, implementation and Monitoring and Evaluation (M&E) of Gavi HSS support.

- **Gavi to critically consider key aspects of the scope and objectives of HSS support.** Whilst Gavi is clear on *what* HSS investments aim to achieve, there is still a lack of clarity around *how* countries can achieve that impact. Gavi should consider whether its HSS window merits further definition, in relation to the objectives, whilst retaining the country-driven and country-owned principles guiding the organisation as a whole.
- **Gavi to provide complete information and improve clarity on its HSS window,** requirements and processes for countries, both for application and during implementation and fund disbursement, identifying the most appropriate mechanisms for providing this greater level of information and clarity to countries in a format most relevant to country needs.
- **Gavi to consider the most appropriate delivery model for HSS support and whether a more “hands-on approach” may be required for select countries.** Our recommendation is that Gavi considers whether variations to its existing model may be appropriate, at least for select “problem” countries.
- **Gavi to conduct a critical assessment of how best to circumvent implementation delays,** as well as consider key implications of the delays.
- **Gavi to consider the appropriate monitoring of HSS grants,** including a greater focus on tracking process and output indicators, measuring the “systems strengthening” impact of HSS investments, and ensuring a clear linkage between monitoring information and follow-up action.
- **Where HSS funding is channelled through Partners, greater clarity is required on processes,** including a detailed assessment of government financial weaknesses and accompanying provision of capacity building support.
- **Gavi to proactively clarify and provide guidance on reprogramming and reallocation of HSS funding** given lack of understanding at country level, as well as ensure that the newly implemented guidance around updating, supplementing and replacing activities and indicators in the performance framework during reprogramming is functioning effectively.

1. INTRODUCTION AND METHODOLOGY

Cambridge Economic Policy Associates (CEPA) has been appointed by Gavi, The Vaccine Alliance (Gavi) to conduct a meta-review of country evaluations of Gavi's Health System Strengthening (HSS) support. This report presents our findings and ensuing recommendations, following discussions with the Gavi Secretariat Monitoring and Evaluation (M&E) team on earlier drafts.

The rest of this section sets out the scope and objectives of the review (Section 1.1), methodology (Section 1.2), and a summary of the HSS grants and evaluations under review (Section 1.3); Section 2 presents the main findings; and Section 3 presents our recommendations. Detailed methodological notes, the evidence database and supporting analyses are provided in the annexes.

1.1. Scope and objectives of the review

As per the Terms of Reference (ToR), the study has been commissioned on the request of the Gavi Board and Evaluation Advisory Committee to provide increased learning and accountability on HSS grants, including more evidence-based data.

The study covers 14 evaluations of country HSS grants approved by the Gavi Board prior to 2012, with the evaluations being conducted over the period 2013-15. The specific objectives of the study are to:

- synthesise the findings regarding Gavi HSS grants (encompassing relevance, implementation, effectiveness, efficiency, results and sustainability) and assess their robustness;
- assess the extent to which Gavi HSS grants have complemented other resources at the country level (if information is available);
- assess the extent to which challenges identified have been addressed through modifications to Gavi's approach to HSS over time and make recommendations for additional improvements; and
- help countries and the Alliance in their ongoing efforts to improve the HSS window, with a particular focus on implementation.

The study also entails a review of the main findings on HSS grants from the ongoing Full Country Evaluations (FCE) project and recent Independent Review Committee (IRC) reports in terms of the extent to which these corroborate or contradict the findings of the country HSS evaluations. The HSS proposals and grants covered by these sources are as per Gavi's *current* HSS window design, and hence while the findings might not be directly comparable with that in the country HSS evaluation reports in all cases given changes overtime, they also provide evidence on the

extent to which challenges noted in Gavi’s initial HSS window design may or may not have been subsequently addressed. Annex 1 provides a full list of references consulted for the review.

1.2. Approach and methodology

Our approach and methodology for the meta-review comprises three main elements:

1. Development of an “a priori” analytical and coding framework for synthesis of evidence from the country HSS evaluation reports

Based on the objectives of the review and content of the evaluation reports, we have developed an analytical and coding framework encompassing the following four dimensions (Annex 2 provides the detailed analytical and coding framework):

1. *Relevance and alignment* – covering alignment with country policies and needs, adherence to Gavi’s HSS goals and objectives, complementarity with other donor resources in the country.
2. *Efficiency and effectiveness* – covering the proposal development and grant implementation processes in the country, including country programme and financial management, support from the Gavi Secretariat and Partners, functioning of the Health Sector Coordination Committee (HSCC), timeliness, coordination, etc.
3. *Results and impact* – covering achievement of proposal objectives, impact on health and immunisation systems and outcomes, unintended consequences.
4. *Sustainability* – covering potential for sustainability and whether there is any evidence of activities being sustained.

All 14 country reports have been reviewed from the perspective of this framework and key findings (where available) have been synthesised as per this standardised framework.

These findings have then been coded (as relevant for each specific issue at hand) based on the information provided in the evaluation reports. For example, on relevance and alignment, we have coded the synthesised information as “full”, “partial” or “no” alignment; on efficiency and effectiveness, we have coded the synthesised information as “highly effective”, “effective”, “improving” and “poor”; etc. The coding has facilitated an analysis of the information collated from the reports. To ensure consistency in coding, data entries have been cross-checked by team members.

Annex 3 provides the summary evidence collated from the country HSS evaluation reports, including the coding of the evidence.

We have also considered key country context factors (such as income levels, DTP3 coverage rates, fragility status, etc.) and “evaluation type” (i.e. Gavi or country commissioned) and assessed

whether these factors have any impact on our findings through a basic correlation analysis. Details are presented in Annex 4.

2. Consideration and presentation of findings

Based on the synthesis of evidence across the 14 evaluation reports, we have identified the main findings on the above-noted four dimensions.

As this is a meta-review, our approach has been to consider findings that resonate across countries, rather than focus on country-specific findings.

3. Assessment of robustness of findings

Robustness of findings is based on both the underlying quality of the evidence, as well as triangulation, or quantity, of the evidence.

In terms of quality, we have reviewed the quality of the 14 evaluation reports, by considering aspects such as “validity” and “reliability” of the methodology used in the report, including:

- i. *Coverage of all main stakeholder groups* – government, Gavi Partners in country, other donor/ multilateral organisations operating in the country, Gavi Secretariat, Civil Society Organisations (CSOs), etc.
- ii. *Use of a mixed-methods approach* – at least a mix of desk-based review and consultations, with stronger methodology being represented by the additional use of methods such as surveys, quantitative analysis, comparator assessment, etc.
- iii. *Well-rounded coverage of all key issues* – consideration of the full spectrum of the HSS grant from design to implementation to results, the five OECD DAC criteria, etc.
- iv. *Quality of analysis* – whether conclusions are based on robust evidence and/ or are sufficiently caveated. Other issues include whether the report reflects a sound understanding of evaluation criteria as well as the extent to which the lessons learned and recommendations sections are sufficiently developed and build on key findings.

Then, our methodology for the summary quality assessment has been as follows:

- Each of the aspects (i)-(iv) have been rated as “good”, “mixed” or “poor” based on our review of the evaluation reports. The assessment has been cross-checked by team members to reduce subjectivity in the rating.²
- To improve objectivity of the rating, we have summed up the ratings, based on: good = 1, mixed = 0, and poor = -1, and presented a summary rating on the quality of the report, as

² The Nepal HSS evaluation report was developed by CEPA. To reduce bias, a CEPA staff member not involved in the evaluation has reviewed the report for the various quality assessment criteria outlined above.

follows: “strong” = sum of 4, “good” = sum of between 1 to 3, “limited” = sum of 0, and “poor” = negative sum. This detailed rating has been introduced on the specific request of the Gavi Secretariat given we understand that they would like a clear distinction in the quality of the various evaluation reports.

Annex 3 provides the detailed assessment of the quality of the 14 evaluation reports.

In terms of quantity, we have assessed the extent to which findings can be triangulated across the country HSS evaluation reports and corroborated by the FCE findings and IRC reports. While measuring quantity, we carefully consider whether the reports only state the issue or provide details/ evidence in support of the stated issue.

Bringing together these aspects of quality and quantity, we have adopted a four-point scale for the robustness rating as described in Table 1.1 below.

Note that we have accorded higher weight to the country reports in comparison to the sources being used for corroboration (i.e. the FCE and IRC reports), given that: (i) the set of 14 reports is a reasonably large sample size; (ii) the different time periods (and consequently Gavi HSS structure) covered by the country HSS evaluation reports and the FCE and IRC reports; and (iii) our view on an appropriate scale given the qualitative nature of the study. This is different from the approach employed in the previous meta-review report, wherein equal weight was accorded to the three sources. As such, we have clearly delineated this difference in approach by expanding the rating description in the table below. Also, for simplicity, we have grouped the “strong” and “good” quality reports as being of good quality, and the “limited” and “poor” quality reports as being of poor quality.

Table 1.1: Robustness rating for emerging themes/ main findings

Rating	Description
Strong	<ul style="list-style-type: none"> • The finding is supported by majority of the evaluation reports which are categorised as being of good quality; or • The finding is supported by majority of the evaluation reports as well as the FCE and IRC reports
Good	<ul style="list-style-type: none"> • The finding is supported by some of the evaluation reports which are categorised as being of good quality or by majority of the evaluation reports with a mix of good and poor quality; or • The finding is supported by majority of the evaluation reports as well as one of two sources being used for comparison (i.e. the FCE or IRC reports)
Limited	<ul style="list-style-type: none"> • The finding is supported by some of the evaluation reports which are categorised as being of poor quality; or • The finding is supported by some of the evaluation reports as well as one of two sources being used for comparison (i.e. the FCE or IRC reports)
Poor	<ul style="list-style-type: none"> • The finding is supported by very few evaluation reports of poor quality; or

Rating	Description
	<ul style="list-style-type: none"> The finding is supported by some/ few evaluation reports only and not by any of the two sources being used for comparison (i.e. the FCE or IRC reports)

All robustness rankings are *relative* robustness rankings, based on careful consideration and are ultimately judgement-based.

1.2.1. Methodological limitations

A summary of the limitations of this study are included below, with a full discussion presented in Annex 5.

Key limitations
<ul style="list-style-type: none"> <i>Exclusive reliance on evaluation reports</i> with no provision to collect additional information, meaning the quality and robustness of findings and conclusions for the meta-review are dependent on the content, quality and robustness of each of the country evaluations. Where more detailed information or discussion is not provided in these reports which would have been relevant for Gavi, we flag this and, as appropriate, recommendations have been formulated to address this. <i>Element of judgement in qualitative analysis</i>, although the process and analytical framework have been clearly documented to ensure transparency. <i>Potential bias between evaluation types (i.e. Gavi or country commissioned)</i>, given the underlying reason for undertaking the evaluation. <i>Limitations of robustness through use of IRC and FCE reports</i>, given that these reports cover a different time period than the country evaluation reports and that the FCE reports are prospective in nature.

1.3. Country and evaluation context

The meta-review comprises evaluations of HSS grants provided to 14 countries (Table 1.2).

Table 1.2: Background on HSS grants and evaluations

Country	HSS grant amount	Gavi/ country commissioned	Period covered by evaluation	End/ Mid-term eval.	CEPA rated quality of report
Afghanistan	\$34.1m	Country	2008-13	End	Strong
Burkina Faso	\$4.98m	Gavi	2008-12	End	Good
Cameroon	\$12.33m	Gavi	2007-14	End	Good
Chad	\$4.98m	Gavi	2008-14	End	Good
Eritrea	\$2.78m	Country	2010-14	End	Poor
Ethiopia	\$76.49m	Gavi	2006-12	End	Good
Ghana	\$9.67m	Country	2007-13	End	Poor
Madagascar	\$11.22m	Gavi	2008-14	End	Strong
Myanmar	\$32.77m	Country	2011-13	Mid	Good

Country	HSS grant amount	Gavi/ country commissioned	Period covered by evaluation	End/ Mid-term eval.	CEPA rated quality of report
Nepal	\$14.48m	Gavi	2010-14	End	Strong
Somalia	\$11.55m	Gavi	2011-16	End	Good
Sudan	\$16.15m	Country	2008-13	End	Poor
Tajikistan	\$1.31m	Gavi	2008-14	End	Strong
Yemen	\$6.34m	Country	2007-13	End	Limited

This is a wide-ranging sample of countries in terms of geography, fragility, income levels, health and immunisation status, etc. However, there are some “outliers” in terms of health systems structure and governance (e.g. the important role of CSOs in Afghanistan, lack of a national health policy and specific security challenges in Somalia, etc.).

All of the HSS grants under review were approved in the early years of the Gavi HSS window (that is, before the introduction of Performance-Based Funding (PBF) in 2012 explicitly requiring countries to link HSS outcomes to immunisation results), and hence are similar in that they are based on the initial structure of Gavi HSS. But there have also been some particular features of specific grants e.g. HSS support through a pooled fund, focus on pilot programmes as compared to general health systems support, amongst others. An important point is that 9 of the 14 grants have been reprogrammed and/ or reallocated³, resulting in many grants being completed only recently (and some with ongoing activities). Thus majority of the grants have been implemented over a long time period, when the Gavi HSS window has undergone some restructuring and reform, alongside broader organisation-wide changes over Gavi Phases II-IV.

The study includes eight evaluations commissioned by Gavi to understand particular experiences of countries and six evaluations commissioned by countries to inform subsequent applications. The difference in who has commissioned the evaluation and the basic objective for commissioning has resulted in a degree of variance in the scope and content of the reports (a full discussion is provided in Annex 6). Country-commissioned evaluations focus more on progress and challenges in implementing HSS activities, and whether or how different/ additional strategies may be relevant for country implementation of those activities going forward, as compared to processes and management of the grant. There is also a notable lack of information on relevance/ alignment with country needs and Gavi HSS objectives in these reports. In contrast, Gavi-commissioned reports provide a richer analysis of process/ management issues (including roles of Secretariat, Partners, countries) and also aim to evaluate the specific role and contribution of Gavi and whether Gavi HSS support has been catalytic and complementary.

³ As discussed in more detail in Section 2.2: Key finding 8, there is a lack of clarity provided in evaluation reports as to whether countries *reprogrammed* or *reallocated* their HSS grants (notwithstanding the substantial difference between the two types of grant modifications).

Further, our assessment of the quality of reports indicates that all Gavi-commissioned reports have been of good quality (i.e. rated as either “strong” or “good” as per our detailed assessment), while most of the country-commissioned reports have been of poor quality (almost all have been rated as “limited” or “poor” as per our detailed assessment). However, we would also caution against too much emphasis on this dichotomy as the above-noted differences in the content of the two types of reports has also implied better coverage of issues by the Gavi-commissioned reports for this meta-review (which has been one of the criteria used in our robustness rating).

2. KEY FINDINGS AND CONCLUSIONS

Key findings from the meta-review are presented below in terms of relevance and alignment of HSS support to countries (Section 2.1), efficiency and effectiveness of implementation (Section 2.2), emerging evidence on results and impact (Section 2.3) and potential for sustainability (Section 2.4). Our assessment of the robustness of each finding is also presented alongside.⁴ Finally, a summary discussion of findings is presented in Section 2.5.

The full evidence database supporting our conclusions is provided in Annex 3. A summary matrix on our robustness assessment is provided in Annex 7.

2.1. Relevance and alignment

Key finding 1: Gavi HSS support to countries has been well-aligned with their health sector policies and plans, however weak country planning capacity has implied that several grants have not been designed effectively, thereby somewhat diluting their relevance.

Robustness rating: Strong				
Of the 13 evaluations that discuss alignment with country plans, 12 indicate alignment, of which 8 reports are rated as being of good quality. ⁵ There is an almost balanced finding on the issue of good versus poor grant design, with 6 of the 13 reports supporting the latter view (majority of which are rated as being of good quality). The FCE and IRC reports do not fully support this finding on account of the changing focus of Gavi HSS support from Phases II-III, and hence does not impact our robustness rating.				
Issues	# reports support/ # reports discuss issue	Report type Gavi / Country ⁶	Report quality Good / Poor ⁷	Supported by FCE / IRC?
Alignment	12/13			-
Grant design	6/13			-

Our review of the country HSS evaluation reports included in this meta-review suggests that Gavi HSS grants have been well-aligned with the country health sector policies and plans. Discussions around this issue in the evaluation reports indicate alignment with a range of country policy documents (e.g. health policy, health strategy, health sector vision, comprehensive Multi-Year Plan (cMYP), etc.). Further, some country HSS proposals and grants have also initiated health assessments and plans (e.g. in Myanmar, a 12-month in-depth assessment was undertaken; in

⁴ The data on the number of Gavi- and country-commissioned reports is presented for information only and has not been used to assess the robustness rating.

⁵ The only country where alignment with country plans and policies has been weak is Somalia. The evaluation report notes that key policy documents were launched after the start of the implementation of HSS activities and the proposal was not based on adequate evidence-base and consideration of country capacity.

⁶ Legend – black refers to Gavi-commissioned and white to country-commissioned reports (here and in all tables below), as intimated through the highlighted colors on the column heading.

⁷ Legend – black refers to good and white to poor quality reports (here and in all tables below), as intimated through the highlighted colors on the column heading.

Eritrea, one of the objectives of the HSS grant was the development of the country Health Sector Strategic Development Plan).

However, despite most country evaluations indicating alignment, there is somewhat mixed experience on whether the HSS grants have been well designed to effectively meet country needs. In particular:

- For some countries (7), proposal development is noted as being based on “critical gap analysis” and sound evidence base. For example, the Madagascar evaluation report states that the IRC had commented that the bottlenecks analysis and related strategy development was well conducted.
- But for other countries (6), the HSS grants have not been suitably designed, thereby somewhat diluting their relevance. Key issues identified across evaluation reports include inadequate consideration of country capacity for delivery (Cameroon, Somalia), poor selection of focus districts (Cameroon, Chad), need for consideration of focus areas other than those identified (Cameroon, Chad, Ethiopia, Somalia) and coverage of too many activities with insufficient budget allocation (Eritrea). These issues indicate weak country planning capacity, contributing to inadequate or poor analysis of objectives and activities for the HSS grant.

The recent IRC report (March 2015) presents a somewhat different perspective. Their review of 10 HSS proposals suggests lack of alignment with broader national health sector strategic plans, resulting in 5 of 10 proposals requiring resubmission.^{8,9} They find that the majority of the country proposals suggest “verticalisation” of immunisation, without adequate consideration of integrating immunisation within primary health care and the broader health sector.

Our assessment is that this reflects the changing focus of Gavi HSS support, which over time has become more immunisation-focused, and hence now presents the new challenge of ensuring alignment with the broader health sector.

The IRC report also finds that HSS proposals have improved over time, with “*sound bottleneck analysis, clearer objective setting...*”. Issues are still however flagged in terms of budgeting, M&E frameworks, etc.

⁸ Two of these are FCE countries (Zambia and Bangladesh), with the FCE report findings being aligned with that of the IRC.

⁹ We note that the 2016 HSS Guidelines (Section 5.2, page 12) provide specific examples of how alignment of HSS support can be shown, which is the first time this guidance has been provided.

Key finding 2: In terms of adherence with Gavi’s mandate, there has been wide variation in the interpretation of Gavi HSS support, with countries generally being unclear on Gavi’s scope and objectives for the HSS window.

Robustness rating: Good			
Majority of the evaluation reports do not explicitly discuss this issue and hence we have endeavoured to reach a conclusion based on the stated objectives of the grants and broader discussions in the evaluation reports. 3 reports provide a more detailed review of this issue, all of which are rated as being of good quality. Key finding of 2015 FCE, enhancing robustness.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
3/3	●	●	FCE

We have reviewed the relevance of Gavi HSS support to countries from the perspective of the priorities and mandate of Gavi (i.e. immunisation focus, key principles of being catalytic and value-add, etc.) and conclude the following:

- Country HSS grants have included a mix of broad HSS to specific immunisation-focused objectives. While some grants have focused on health systems bottlenecks as a whole and overall delivery of maternal and child health services, others have focused on immunisation-specific outcomes. The objectives are also positioned at different levels in terms of improved health outcomes (e.g. immunisation coverage) and activities (e.g. improved data). This finding is not unexpected given Gavi’s 2007 HSS Guidelines are also broad in terms of the focus of the HSS grants.¹⁰
- There has been some lack of clarity amongst countries on how best to programme their funding from Gavi (Burkina Faso, Chad, Nepal). This is not only in terms of the broad versus specific focus of HSS discussed above, but also in terms of whether and how to use HSS support in a catalytic or value-added manner (especially where Gavi HSS represents a small proportion of the total country funds for HSS, for example, in Burkina Faso).

These findings are reiterated throughout the 2015 FCE report, which highlights the complexity of Gavi HSS support and the limited understanding at the country level, as well as a failure to harness the catalytic nature of HSS funding.¹¹

¹⁰ The guidelines state: “The objective of GAVI HSS is to achieve and sustain increased immunisation coverage, through strengthening the capacity of the health system to provide immunisation and other health services (with a focus on child and maternal health).” and “Countries are encouraged to use GAVI HSS funding to target the “bottlenecks” or barriers in the health system that impede progress in improving the provision of and demand for immunisation and other child and maternal health services.”

¹¹ Surprisingly, the two 2015 IRC reports do not touch on this issue.

Key finding 3: Gavi HSS funds have been coordinated with and complemented other donor funds in countries, especially where HSS funds have been channelled through country pooled funds.

Robustness rating: Limited				
9 evaluation reports provide information on coordination by design (i.e. as per the proposal) and 10 reports also comment on coordination during implementation. Majority of these reports suggest good or partial coordination, however details are very limited and lack evidence, and hence the overall robustness rating has been marked down. Further, we note that the sample of pooled fund countries is only 2. One FCE report supports this finding.				
Issues	# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
Coordination by design (i.e. as per the proposal)	9/9 (limited information)			FCE
Coordination during implementation	7/10 (limited information)			FCE

Of the reports which provide information on this issue, the majority indicate complementarity and coordination with other donor funding. A strong example is that of Afghanistan where it is noted that: (i) Gavi HSS support complemented rather than competed with other donor support; (ii) served as a catalyst and tried to fill the gaps left from other donors – particularly in remote areas where health services do not exist; and (iii) other donor funds were reprogrammed to align with Gavi support (as also flagged in the evaluation for Burkina Faso and the Mozambique 2015 FCE report). One of the key roles of the HSCC is to ensure donor coordination and indeed we find some correlation between countries with functional HSCCs and coordination of donor funding.

Coordination is particularly enhanced in the case of Gavi HSS support to country pooled funds. For example, the Nepal report clearly states the complementarity with other donors due to the pooled fund mechanism and outlines the added benefits of this approach as reducing transaction costs for the country and consequently allowing for greater focus on delivery of results, as well as enabling greater leverage of Gavi HSS funds. In the Ethiopia report, it is stated that Gavi was the first contributor to the pooled fund, after which other donors followed, resulting in resource pooling to fund the priorities of the national health plan.

Countries with lack of coordination during implementation of HSS grants include Somalia, Chad and Yemen. For example, in Somalia, the Gavi and Global Fund HSS grants were not coordinated; in Chad, the Reach Every District (RED) initiative began in 2013, with eight of ten districts receiving both RED and Gavi HSS funds.

2.2. Efficiency and effectiveness

Key finding 4: The proposal development process has been somewhat participatory, although often lacking CSOs, and concerns have been raised on representation and adequate guidance from the Gavi Secretariat and Alliance Partners.

Robustness rating: Strong			
10 country HSS evaluations discuss this issue, 7 of which are rated good quality. The March and June 2015 IRC reports as well as the 2014 and 2015 FCE reports corroborate majority of the findings.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
10/10			FCE IRC

The vast majority of country HSS evaluations report the proposal development process to have been participatory, with a range of stakeholders involved across Ministry of Health (MoH) departments, Gavi Alliance Partners (WHO, UNICEF) and country-based donors. However:

- The 2007 HSS guidance which “strongly encourage[s]” countries to involve CSOs and the private sector is not well adhered to, with some evaluations (4) reporting that CSOs were not included in the process and only one report explicitly noting the involvement of the private sector (Burkina Faso).¹² Where CSOs are referenced in the proposal development process, some reports also comment that they were only consulted briefly and not involved actively. The IRC reports from March and June 2015 also indicate lack of adequate participation of CSOs.
- Some countries (4) note the process to have been “top down”, with lack of sub-national and district level representatives. This may be due to the costs involved, and indeed the 2014 FCE report states that the proposal development process is challenging to operationalise. However, this has impacted on the relevance of programme design, often seen as being a “missed opportunity for valuable insights into ground level realities” (Ethiopia).
- None of the country evaluation reports suggest the involvement of the Ministry of Finance, except Afghanistan. Indeed, the 2014 FCE report makes the specific recommendation to increase efforts to integrate the Ministry of Finance into decision-making and planning processes, due to an observed limited involvement.
- Two countries note having relied heavily on consultants for proposal development (Burkina Faso, Chad). This is also evidenced through the findings of the 2015 FCE report, which further critiques this as being ineffective, due to the consultants’ low level of

¹² It should be noted that between 2007 and 2012, Gavi provided separate funding for CSO support, which is likely to have reduced CSO participation in HSS proposal development during this period.

relevant knowledge and insufficient engagement with other stakeholders (Bangladesh, Zambia).

Furthermore, whilst Gavi Partners, WHO and UNICEF, are noted as being present during proposal development for the majority of countries, *this support is overwhelmingly viewed as technical support rather than also as a representation of the Gavi Alliance*. Some countries (4) specifically flag the “lack of Gavi presence” during the proposal development and note a lack of clear guidance from Gavi on the proposal process.¹³ Indeed, most of the Gavi-oriented recommendations provided across all of the reports relate to the lack of guidance on HSS proposal design. The 2014 FCE report also indicates the need for more communication and guidance on Gavi’s requirements and procedures (discussed further under key finding 9 below). It should however be noted that the Madagascar HSS evaluation report viewed Gavi as being “helpful in supporting proposal development and was responsive to their questions”.

Country-commissioned evaluations tend to provide a less critical view of this process, with three out of five reporting a fully participatory process, compared with one out of five for Gavi-commissioned evaluations.

Also, we note a changing view across the HSS evaluation reports and the recent IRC reports, with the former set noting that a range of MoH departments are often involved in proposal development (which is noted as a particular strength in some countries such as Afghanistan and Yemen) and the latter indicating greater engagement of immunisation sector stakeholders and lack of involvement of the wider health sector stakeholders, on account of the perceived growing immunisation focus of Gavi HSS support (as also discussed under key finding 1).

Key finding 5: Country programme management has been poor, primarily on account of weak country capacity coupled with poor planning.

Robustness rating: Strong			
This issue was discussed in 12 country reports (9 rated good quality), none of which suggest well-functioning or highly effective programme management. 2014 and 2015 FCE reports describe similar and additional challenges.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
12/12			FCE

¹³ Most evaluation reports are not clear on whether they are referring to the Gavi Alliance, the Partners or the Secretariat when they refer to “Gavi”. This is flagged as a limitation in our review (Annex 5).

In most countries, appropriate leadership, coordination, decision-making and/ or work-planning capacity and procedures were not established in country, either as part of the proposal development process or prior to project commencement.¹⁴ In particular, there has been:

- lack of relevant and adequate capacity/ skills for programme management, including dedicated leadership (Burkina Faso, Cameroon, Chad, Tajikistan, Yemen, Nepal);
- lack of clear planning for programme management, including for example, determination of the work plan and/ or key procedures and tools such as for decision making, problem solving, etc. (Cameroon, Chad, Madagascar, Burkina Faso, Sudan);
- a series of issues relating to government systems in general including high staff turnover and related loss of institutional memory, lack of commitment, etc.;
- allocation of implementation responsibilities across multiple departments without clearly defined roles and responsibilities as well as coordination structures (Burkina Faso, Somalia) and rigid management structures that did not work for complex tasks/ innovations (Burkina Faso);
- poor governance and oversight (Burkina Faso, Madagascar, Somalia) – also discussed under key finding 6 below;
- poor financial management capacity – as discussed under key finding 7 below.

Further, there has been a lack of appropriate and timely guidance from the Gavi Secretariat and Partners (Chad, Tajikistan), contributing to challenges in programme management (discussed under key finding 9 below).

Programme management capacity has also been weakened by “macro” country issues (e.g. the political crisis in Madagascar), challenges in improving health systems in poor and fragile countries (e.g. poor infrastructure, weak procurement and supply chains – e.g. in Nepal, Somalia, Ethiopia, Madagascar) and lack of adequate data to support decision making and implementation.

It is interesting to note that of the 12 country evaluation reports, the country-commissioned ones (4) present a slightly better review than the Gavi-commissioned ones (8). Further, the country

¹⁴ Majority of the evaluation reports state that a dedicated management structure was created within the MoH to manage the HSS grant (although limited information is provided in terms of the pros and cons and comparisons with other options). In a few countries, Gavi HSS programme management was integrated in the existing institutional structures – e.g. in Ghana, where the evaluation report is generally positive on the functioning (also information is limited); and in Burkina Faso, where the report notes the benefits of not creating a separate management unit, but also flags that this approach causes issues for effective implementation. The IRC reports also state varying experiences: the March 2015 IRC report states that almost all countries proposed management units within existing institutions while the June 2015 IRC report states that most proposals included a standalone management unit and parallel structures.

reports indicate some approaches which may be regarded as best practice – e.g. in Sudan, the coordination of Gavi and Global Fund HSS grants was consolidated in a single committee; in Yemen, the main focus of the HSS grant was integration of Expanded Programme on Immunization (EPI) and other health services for which a technical committee was created comprising programme directors from all relevant health services.

The 2014 FCE report also notes that limited planning and management capacity is an important bottleneck for Gavi HSS support and the 2015 FCE report dedicates a full section to this issue, flagging several instances of countries implementing Gavi support beyond their programmatic capacity. The FCE reports flag several further issues, including the “cumulative effect” of multiple Gavi grants compromising the ability to manage all effectively, the oversized administrative and management burden of Gavi grants and processes, unrealistic timelines included in proposals resulting in limited ability to adaptively manage grants and ineffective technical assistance aimed at strengthening management capacity.

One may argue that the programme management challenges facing countries included in this meta-review are not representative of other countries, given that nine of the 14 have reprogrammed and/ or reallocated.¹⁵ However, we do note that this issue has also been flagged in the FCE reports and hence view this as generalisable, although the extent of the problem may vary by country.

Key finding 6: Country HSCCs have generally functioned as intended during the proposal stage. However, they have not functioned well during grant implementation.

Robustness rating: Good/ Limited			
Supported by 11 reports, 8 of which are rated good quality; however often reports do not provide much detail. The March 2015 IRC report does not fully support this finding on account of some changes in Gavi HSS support from Phases II-III, and hence does not impact our robustness rating.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
11/11			-

One of the requirements for HSS grants is that they should be monitored by a forum of partners and Government planners who make decisions that affect the health sector, not restricted to immunisation. Whilst the 2006 Guidelines refer to such a body as being responsible for proposal development, Annual Progress Reports (APRs) approval and fund management, the 2007 Guidelines expand this responsibility to the full grant management cycle and explicitly state that “a new committee should not be created if an existing committee fulfils the required functions” (p. 7).

¹⁵ See discussions in key finding 8 for further detail.

All country HSS evaluation reports which discuss this issue note some form of HSCC to be in place, with almost half (5) having created an HSCC specifically for the Gavi HSS proposal. In several countries, this governing body appears to only have been used for proposal development, approval of APRs and/ or reprogramming requests, rather than as the intended governance and oversight mechanism for overall grant implementation (e.g. Chad, Burkina Faso, Madagascar, Myanmar and Tajikistan). Where the HSCC has played this larger role, the governance and oversight provided by the HSCC is deemed cursory and high-level and not detailed enough for effective governance (Tajikistan). Limited follow-up by the HSCC on delays and programme bottlenecks has also contributed to delayed grant implementation. Indeed, one report recommends that Gavi should better define minimum governance benchmarks in order to guide this process as well as provide capacity building for members (Afghanistan).

The IRC March 2015 report states that: *“Although in many countries there are existing ICC mechanisms, broader health sector coordination mechanisms and NITAGs are neither identified nor technically supported to inform or perform decision making and coordination of investments for either HSS or new vaccine introductions”*. This finding is different from that emerging from the country HSS evaluation reports, and appears to be aligned with the broader findings of the IRC reports on the “verticalisation” of immunisation (i.e. as described under key finding 1).

Key finding 7: Country financial management capacity and procedures have been weak, and coupled with poor programme management, have resulted in low absorption and delayed disbursements. Gavi’s FMA requirements have increased complexity and added to delays.

Robustness rating: Good/ Limited			
This finding is supported by 8 country evaluations, 7 of which rated good quality. 2014 and 2015 FCE reports support some findings, while the June 2015 IRC report contradicts some findings.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
8/8			FCE

Corresponding to the finding on programme management, several issues have also been cited with regard to in-country financial management, including:¹⁶

- Lack of in-country capacity for financial management, including reporting (Somalia, Madagascar, Chad, Tajikistan);
- Cumbersome government procedures for financing (Madagascar);

¹⁶ It should be noted that country evaluation reports do not provide an adequate level of detail on financial management issues to be able to identify the “root cause” of the problem, for example whether this is in terms of ability to receive funds from Gavi (e.g. FMA, adhering to the Aide Memoire, providing Gavi with timely and accurate reports) or internal management issues (e.g. ability to transfer funds from national to sub-national levels).

- Poor budgeting and work planning (Chad);
- Lack of coordination with programme management, with responsibilities for programme and financial management often separated (Burkina Faso);
- Slow responses from countries on clarifications from Gavi (Chad).

As such, and coupled with the challenges of programme management discussed previously, there has been low absorption of Gavi funds by countries, with several delayed disbursements as well as incomplete utilisation of the full HSS grant (Burkina Faso, Ethiopia, Sudan).¹⁷

Further, poor financial management has led to suspension of funds by Gavi in some countries. However, Gavi's fiduciary management requirements (initial due diligence steps, including Financial Management Assessment (FMA), audits, Partnership Framework Agreement (PFA), Aide Memoire etc.) have been viewed as complex by countries, adding further delays. The 2014 and 2015 FCE reports also note delays in disbursements, notably for Bangladesh and Mozambique, partly due to FMA requirements and Gavi's complex financial management processes.

On the positive side, where funds were disbursed through a pooled fund or joint management of funds (Nepal, Ethiopia and Sudan), there is evidence of more effective processes and reduced transaction costs (although there are still delays).

Funding channelled through Gavi Partners (WHO and UNICEF) due to weak government capacity has been criticised for the lack of clarity in roles and responsibilities, as well as high management fees incurred and implementation delays due to the additional layer of bureaucracy (Cameroon, Chad, Somalia). However, the June 2015 IRC report notes a much higher proportion of HSS grants (44%) channelled through Partners, and finds this to be particularly relevant for post-conflict or fragile countries.

Our assessment of the findings presented above is that effective and efficient financial management is impeded by both weak country capacity and complex and bureaucratic Gavi procedures. Country HSS evaluations highlight both reasons, the FCE reports focus on the latter and the IRC reports provide justification for the latter.

¹⁷ There has also been some variations in planned versus actual expenditures (Tajikistan, Madagascar), although most evaluation reports are unable to assess this in detail due to lack of complete information.

Key finding 8: Whilst reprogramming of country grants has resulted in greater relevance for countries and increased immunisation focus, there is a general lack of understanding of this process at the country level and significant transaction costs have been incurred.

Robustness rating: Good			
Of the 9 countries which reprogrammed, most reports present a reasonable level of detail on the reprogramming experience and have been rated as being of good quality. 2014 and 2015 FCE reports provide some information.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
9/9			FCE

Gavi provides the opportunity for countries to amend their HSS grants in order to meet evolving needs and priorities, through either *reprogramming* (if a significant change to the grant objectives and/ or activities and related budget allocation is required) or *reallocation* (if a relatively small restructuring of the originally approved HSS budget, without significant changes in the overall grant objectives and activities, is required).¹⁸ Whilst the majority of country evaluations (9) report having amended their HSS grants – and several of which multiple times – there is a lack of clarity in the reports as to whether this was a reprogramming or reallocation of the grant. In four of the nine reports, the two terms are used interchangeably, although greater emphasis is given to reprogramming. The remaining five refer only to reprogramming, although none of the nine reports provide adequate information to ascertain which process was followed.¹⁹ This highlights a lack of understanding at the country level on these two processes.

Nevertheless, most of these countries have positively noted the flexibility afforded by Gavi in allowing amendments to existing grants, which has enabled activities to be changed to better meet country needs (Afghanistan, Eritrea, Ghana, Sudan, and Ethiopia). In all cases where grants were reprogrammed and included a change in HSS objectives, there has been a heightened immunisation focus (Madagascar, Cameroon, Eritrea, Somalia and Chad). This is also not unexpected, as this reprogramming would have occurred towards the end of Gavi Phase II, where the objectives for the HSS window were also being revised to be more immunisation-focused.²⁰

However, significant transaction costs have been incurred through this grant reprogramming, with seven countries having experienced significant delays to implementation, which in some cases is partly attributed to the length of time required for approval of amendments. The Cameroon report notes that substantial time, money and energy has been spent on

¹⁸ Definitions as per 2016 HSS guidelines.

¹⁹ Following discussions with Gavi Secretariat, further information was provided on reprogramming and reallocation of these HSS grants. However, this information did not clarify the issue, due to some conflicting information. Hence, the discussion presented here is based on information from evaluation reports only.

²⁰ A detailed discussion of the changing focus of Gavi HSS support is provided in the Nepal evaluation report, also conducted by CEPA.

reprogramming. This is further evidenced by the FCE reports, with both Bangladesh and Uganda noting the long time period required. In addition, grant M&E has been further complicated through reprogramming, with several instances of lack of understanding or approval of indicators, and subsequent inability to monitor performance across the full life of the grant.

Key finding 9: Gavi’s model of delivery for HSS in terms of guidance and support from the Secretariat and Partners has not functioned effectively. There is a need and request from countries for a more “hands-on” model.

Robustness rating: Strong			
10 country evaluations discuss this issue, 8 of which rated good quality; 3 reports in particular site considerable challenges. 2014 and 2015 FCE Reports and March 2015 IRC report support finding.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
10/10			FCE IRC

Our review of the evaluation reports comprising this meta-review suggests a number of challenges with Gavi’s model for delivery of HSS through the Geneva-based Secretariat and in-country Partners. While we understand that Gavi’s “hands-off” model is based on its desire to encourage country ownership and avoid duplication and transaction costs in the global aid architecture, this has resulted in ineffective support for countries, who are expecting more pro-active assistance.

There are challenges across the grant cycle – specifically:

- During proposal development.** As noted previously (key finding 4), country proposal development has not involved active participation from “Gavi”, neither in terms of presence of the Secretariat nor with regard to WHO and UNICEF acting as representatives of Gavi (although they have been active as technical partners). Gavi participation, either through the Secretariat or Partners, would have been warranted during proposal development to provide information and clarity on Gavi’s requirements and procedures as well as to provide technical guidance for proposal development/ programming in line with what Gavi would be prepared to fund. For example: the Nepal report describes the considerable confusion caused during the proposal development and approval process due to lack of active communication from Gavi Secretariat or Gavi Partners; the Burkina Faso report recommends that Gavi provides examples and tools to facilitate the selection of interventions which fall within the logic of HSS for immunisation; and the Ethiopia report recommends that Gavi provides input during the proposal development to share their expertise and experience from other countries with similar contexts.
- During grant implementation.** Many countries have noted the need for guidance from Gavi to help address implementation challenges and better understand Gavi’s

requirements and processes (Cameroon, Chad, Nepal, Tajikistan, Somalia, Sudan). There are several examples of delayed responses from the Gavi Secretariat, inadequate communication on grant approval and fund disbursement processes and timelines, lack of clarity on the roles and responsibilities of Gavi Partners, and challenges with Gavi Partners serving as Gavi representatives and supporting in-country implementation (Cameroon, Sudan, Tajikistan and Nepal).²¹ The 2015 FCE report also notes key challenges emerging due to a lack of in-country understanding of Gavi processes and requirements. The 2015 FCE Report further notes that *“concerted efforts must be undertaken to ensure that countries are aware of and plan according to these timelines”*.

- **Grant monitoring.** It has been indicated that Gavi has often not actively responded to the information provided in the APRs and missed the opportunity to raise issues and steer the direction of progress. For example, the report for Burkina Faso states that *“It would take Gavi 5-7 months to provide responses to APR and failed to suggest solutions to problems encountered”*. A few reports indicate that instances of poor management, both programmatic and financial, continued without being flagged or acted upon by Gavi Partners or the Gavi Secretariat (Cameroon, Chad and Eritrea). Further, in Ethiopia, there was continued non-reporting on certain indicators, which the evaluation points to as a *“major oversight on the part of the GAVI Secretariat in not triggering corrective action to address the weaknesses in this key function of the health system”*.

As such, this review suggests some inherent weaknesses with Gavi’s model of delivery for HSS, where most evaluation reports recommend more active guidance and communications from Gavi. Both the 2014 and 2015 FCE Reports include a specific recommendation of increased Senior Country Manager (SCM) involvement in Gavi HSS, *“consideration of greater in-country presence may improve the partnership structure, and thus outcomes”*. The March 2015 IRC report also provides some recommendations in support of this finding, suggesting that Gavi provides countries with communication development and implementation guidance, with a view to adapting it to suit different country contexts and issues.

²¹ Additional challenges in this regard have applied when Gavi partners have been responsible for financial management as this has limited their ability to also serve as technical partners. The Cameroon report in particular describes this challenge and the need to change project arrangements mid-way to deal with conflicts of interest.

Key finding 10: Gavi HSS grants have experienced substantial delays in implementation.

Robustness rating: Strong			
This is a fact, in that 12 of 13 evaluation reports which provide information on this indicate delays, with there being significant delays for 11 countries. Key finding of 2014 and 2015 FCE reports.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
12/13			FCE

Whilst the issue of delays has been noted previously, the pervasive nature of this issue merits a standalone key finding. Indeed, the majority of Gavi HSS grants have experienced substantial implementation delays (covering both the time lag between proposal submission and approval and the planned versus actual timeframe for grant implementation), leading to deviations from programme design.²²

This issue has been noted across previous findings 5-9, indicating that implementation delays are due to a wide range of reasons, as well as unrealistic expectations of country implementation capacity during proposal design (key finding 1). Additionally, insecurity and political instability in several countries has also contributed to delays.

The 2014 and 2015 FCE reports also note significant delays, highlighting the complex nature of Gavi HSS support, compounded by multiple changes to HSS design over time.

A recent review of Gavi’s direct financial support (Gavi Alliance 2015d) also highlights delays with HSS grants, noting a median time from IRC recommendation for approval to the first disbursement for HSS grants from 2007 to 2014 as being 9 months, with delays due to delayed country responses to clarifications, delays in completing previous HSS grants and delays in signing PFAs. Delays in fund use are also noted, with 52% of funds available in-country in 2014 having been spent, with reasons including late arrival of funds and competing in-country factors.

Key finding 11: Monitoring and reporting systems are not functioning effectively, largely due to poor design at proposal stage.

Robustness rating: Strong			
Of the 12 evaluations which discuss monitoring and reporting, none conclude these systems to be highly effective or effective, with 8 concluding poor systems, of which 7 reports are rated as being of good quality. March and June 2015 IRC Reports as well as the 2015 FCE Report provide support.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
12/12			FCE IRC

²² Whilst evaluation reports provide information on the overall delays, there is not adequate detail to provide a mapping of the extent of these delays.

Monitoring and reporting systems are often not clearly defined in terms of clarity of indicator definition, relevance to HSS programming and overall roles and responsibilities. This is compounded by general challenges with poor EPI and/or Health Management Information System data in countries.

HSS grants tend to be overly focused on outcome indicators, which: cannot be reported on due to lack of available data; are not relevant for Gavi support due to limited impact on overall health system; or are not sensitive enough to measure change that could be attributed to Gavi funding. For example, the inclusion of measuring under-five mortality does not seem appropriate for a three-year intervention with wide, yet sparse, geographic coverage and fragmented activities (Burkina Faso). Several reports therefore include the recommendation to monitor HSS grants through process and output indicators, which are sensitive to change and adequately specific, rather than outcome indicators.

Additionally, several evaluations note the APR does not serve as an adequate monitoring tool, as it is too complicated a process, lacks the ability to trace progress through reprogramming, and there is not an effective process to follow-up on issues raised.

The IRC reports also highlight the continuing low quality of M&E plans and poor definitions of indicators and baselines as a recurring weakness and gap on proposals. The IRC recommends that further guidance be provided to countries on the use of effective international standards for data quality assessment, as has been included in the 2016 HSS Guidelines. Further, the 2015 FCE report refers to the absence of an M&E framework in Bangladesh, hindering grant implementation, and that one of the reasons Zambia was required to resubmit their proposal was due to a weak M&E framework.

This weakness in HSS monitoring is also reiterated in Gavi Board Minutes (December 2014), which state that HSS outcomes are difficult to measure and recommends efforts to obtain more concrete and evidence driven data. The recent DFS (Direct Financial Support) Steering Committee also recommended to focus on intermediate results and process indicators to measure the results of HSS investments.

2.3. Results and impact

Key finding 12: Proposed activities have, for the most part, been completed.

Robustness rating: Good/ Limited			
Of the 12 evaluations which discuss whether planned activities have been completed, 6 provide a detailed review, of which 5 are rated as being of good quality. Limited information is available in the 2014 & 2015 FCE reports.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
12/12			FCE (Limited)

All but one of the reports which provide information on this aspect suggest that most of the planned activities have been implemented (with the exception of Chad) – although given most grants have been delayed (as per key finding 10), the time to implement has been much longer than anticipated.²³

Some reports provide comprehensive reviews, including a detailed tracking of the progress made on various activities. Others state that it is difficult to track activities and their outputs on account of limited supervision of activities (Somalia), unclear targets and baseline information (Yemen), existence of multiple donors beyond Gavi (Sudan) and lack of full clarity on reprogramming targets and related information (Ethiopia, Madagascar).

Due to the prospective nature of FCE reports, there is limited information on overall achievement of activities, with several of the HSS grants in their early implementation stages. The 2014 report indicates limited implementation of HSS activities in Bangladesh.

Key finding 13: There have been improvements in immunisation and health outcomes in most countries, but it is difficult to attribute this to Gavi HSS support.

Robustness rating: Limited/ Poor			
Of the 12 evaluations which discuss immunisation and health outcomes, 8 evaluate that some progress has been made, 5 of which are rated as being of good quality. All reports note challenges with attribution to Gavi funding. This is supported by 2015 FCE report findings.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
8/12			FCE

The majority of the evaluation reports indicate improving immunisation coverage rates, with mixed results on equity (e.g. positive results for Afghanistan, issues flagged in Nepal).²⁴ The 2015 FCE report also concludes that in spite of implementation challenges, some immunisation

²³ The only exception is Chad: “By June 2015 only around 10% of the 2nd reprogramming activities had taken place.”

²⁴ Chad, Ethiopia and Somalia indicate poor progress on immunisation outcomes.

coverage improvements have been made, although with considerable geographical inequities remaining. Some reports also present trends in health outcomes such as mortality rates, noting positive trends.

However, as the country evaluation reports themselves caution, there is a big challenge in attributing these results to Gavi HSS support, given the limited and delayed funding from Gavi, presence of other Gavi and donor funding, “gestation lags”, poor data availability and other confounding factors (e.g. ongoing polio campaigns, selection of good or weak performing districts, etc.).

The small-area estimates method used by the FCE provides an innovative approach for assessing the contribution of Gavi HSS support to immunisation and health outcomes from an observational rather than causal attribution perspective. The report shows that greater immunisation improvements have been made in Gavi-supported districts in Bangladesh, and to a lesser degree, child mortality improvements. Although similar improvements are shown in Uganda and Zambia, little Gavi HSS implementation had been achieved during the time period monitored and so it is less likely attributable to Gavi HSS.

Key finding 14: There is emerging evidence of Gavi HSS support contributing to health system strengthening.

Robustness rating: Good/ Limited			
Of the 13 evaluations which discuss health systems results, 7 evaluate that some progress has been made, of which 5 are rated as being of good quality.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
7/13			-

The focus of Gavi HSS grant M&E and the country evaluation reports comprising this meta-review has been the direct activities, outputs and outcomes of the support. There is a lesser degree of emphasis on measuring the extent to which health systems have been *strengthened*, albeit this is of course the overall objective of Gavi’s support.

Gavi does not provide a formal definition of health system strengthening, only clarifying that the aim of HSS support is to “*address system bottlenecks in order to achieve better immunisation outcomes, including increased vaccination coverage and equitable access*”.²⁵ As such, we make the distinction between health system *support* and health system *strengthening*, with the former referring to interventions which improve outcomes addressing known system bottlenecks by

²⁵ Gavi Alliance (2015). *Guidelines for Applications for Health System Strengthening (HSS) support in 2016*. October 2015

providing inputs. We define the latter to be interventions which encompass multiple health system building blocks, to change policies, organisational structures or behaviour and enable the system to adapt to unknown system bottlenecks.²⁶

Using this defining and based on the information provided in the evaluation reports, we find emerging evidence of health system strengthening through Gavi support, with positive impact on government capacity and planning (Afghanistan, Eritrea, Yemen) and other health system building blocks such as on human resources and service delivery. We note the following examples of “direct” health system strengthening, where this was an intentional outcome of Gavi’s HSS support and often included amongst the programme objectives or activities, including:

- Development of national health policy and plan documents as well as a number of training manuals, health management and committee guidelines, job descriptions and health assessment documents (Eritrea);
- Integration of vertical programmes into the health system (Yemen);
- Improvements in MOH work processes, collaboration and coordination (Afghanistan), thereby improving governance.

In addition, there are several examples of “indirect” health system strengthening or an unintended consequence, including:

- Increased government prioritisation of HSS, such as in Somalia where *"there is broad consensus among partners that HSS is a top priority for the future of Somalia's health system. It has been pointed out by the government and partners that Gavi HSS has played a role to increase the level of interest in HSS in Somalia."*;
- Implementation of HSS through central and provincial government directorates (i.e. without creating parallel structures); and authorisation for the Ministry to procure higher-value services (Afghanistan), thereby supporting capacity building;
- Encouraging greater partner coordination and joined-up planning and management (Cameroon, Yemen, Burkina Faso);
- Encouragement of other development partners to provide HSS support through the government (Sudan).

²⁶ These definitions are adapted from Chee G. et al (2013). *Why differentiating between health system support and health system strengthening is needed*. International Journal of Health Planning and Management 28:85-94

2.4. Sustainability

Key finding 15: There is some evidence of Gavi HSS activities being sustained or there being potential to sustain after the completion of funding, but for the most part, potential for financial sustainability is weak.

Robustness rating: Good/ Limited			
12 country HSS evaluation reports provide a review of sustainability (of which 8 are rated as being of good quality). The assessment is not in-depth and detailed. There have also been different perspectives on how financial sustainability is to be assessed ranging from a general overview of the trends in government budgets for health and immunisations to a specific discussion on key activities supported under the HSS grant. The 2015 FCE report supports the finding.			
# reports support/ # reports discuss issue	Report type Gavi / Country	Report quality Good / Poor	Supported by FCE / IRC?
12/12			FCE

Of the 14 evaluation reports comprising this meta-review, two do not cover the issue of financial sustainability (specifically, for Burkina Faso, this element was removed from the ToR).²⁷ Of the remaining 12 reports:

- Three reports provide evidence of some activities already being absorbed in the government or other donor budgets (or high potential of these being absorbed). This includes: Afghanistan, where Gavi HSS-supported District Health Officers (DHOs) have been incorporated in the regular health budget; Yemen, where some Gavi HSS supported pilot activities have been taken up by other donors; and Nepal, where Gavi HSS pooled fund support has high potential for continuation based on strong government commitment). However, not all activities in these countries are sustainable and risks are flagged with regards to equipment for DHOs and activities such as information, education and communication (IEC) and technical assistance (Afghanistan) and on account of donors generally funding vertical programmes (Yemen).
- Three reports indicate some potential for Gavi HSS activities being sustained after the completion of funding – Ethiopia, where some HSS activities have been integrated into routine programming and the Government has increased commitment to cover some vaccine costs; Madagascar, where some action plan and mappings have been conducted; and Sudan, where government funding is inadequate, but contributions through co-financing have increased.

²⁷ The discussion around sustainability in the evaluation reports has been limited and focused around financial, rather than programmatic sustainability i.e. whether the benefits of the HSS grant have (the potential to) continue. As such, findings are only able to be drawn on financial rather than programmatic sustainability.

- But the remainder (6 reports) indicate high risks with regards to financial sustainability, flagging issues such as not sustaining per diems and salaries funded under Gavi HSS support may result in negative consequences (Myanmar, Somalia). These assessments are based on a number of reasons:
 - Lack of an exit strategy (Cameroon, Chad, Eritrea and also emphasised in the Ethiopia report);
 - Inadequate resources of the government, low commitment from the government to fund immunisation and also default on Gavi co-financing (Ghana, Somalia);
 - Gavi being the only external donor and government take-up not clear (Myanmar);
 - Limited involvement of MoH and EPI in implementation and lack of plans to build government capacity for the pilot project (Somalia).

The 2015 FCE report also states that there has been limited consideration of sustainability in the design of Gavi HSS grants that limit the potential of the window of support to meet its objectives of improving immunisation coverage and equity.

2.5. Summary discussion

As described in Section 1.3, the meta-review of country HSS evaluations brings together the evidence-base from wide-ranging country and HSS grant contexts as well as types of evaluations. Some of the experiences are not typical for all Gavi-eligible countries (e.g. the fragile status of Somalia, the particular challenges faced by Chad with its HSS grant), which limits the generalisability of findings. Also, the fact that nine of the 14 HSS grants under the review have been reprogrammed and/or reallocated indicates that the range of challenges faced by the countries would have been more substantial than the case of a more “standardised” HSS grant. But the spectrum of countries covered, coupled with the FCE and IRC report findings, adds credence to our findings.

Most evaluation reports state that planned activities have been completed – although longer than anticipated timeframes for achievements imply higher transaction costs. The evaluation reports also present information on downstream results, for the most part reflecting improvements, although attribution to Gavi HSS funding is difficult. Importantly, there is emerging evidence of Gavi HSS contributing to *health system strengthening* in countries. These are all positive findings, reflecting the utility and ultimate value add of Gavi HSS support.

The findings also positively indicate that the grants have been well-aligned with country health sector plans and policies, an inherent objective of Gavi’s HSS window. However, this is not corroborated by more recent evidence from the 2015 IRC reports, which suggests that HSS proposals are failing to integrate immunisation within the broader health sector. This

contradiction may be explained by the changing focus of Gavi's HSS window, which is now more immunisation-focused. More generally, we posit that Gavi's evolving intentions for its HSS window, and accompanying changing guidelines, has resulted in a wide interpretation of its objectives and requirements by countries. Given the long term of most of the grants covered under the meta-review and iterations through reprogramming, this has served as a source of lack of clarity and confusion.

Coupled with Gavi's "hands-off" delivery model and challenges with effective representation of Gavi's objectives and procedures by in-country Partners, communications and guidance have not been as forthcoming as needed, and indeed as have often been requested by countries. This is a recurrent issue in many country HSS evaluation reports as well as the FCE reports that track current ongoing HSS grants. Further, the findings indicate that country HSCCs have not always served as effective governance and oversight mechanisms for the lifecycle of the grant (as intended), thereby posing additional challenges for effective and efficient grant management.

Country experience with the HSS grants under review has shown challenges with planning and design, sometimes severe, with many countries lacking adequate capacity to appropriately design HSS funds. While the recent IRC reports suggest improving experience in this regard, challenges remain. Furthermore, we find that weak country programme and financial management capacity – issues also noted in the FCE reports – have rendered considerable challenges in HSS grant implementation. Our sense is that the extent of the problem may have been heightened in the countries covered under the meta-review (on account of the large number that have been reprogrammed and/ or reallocated), but following support from the FCE report as well, we conclude this to be an important challenge to effective HSS grant implementation.

As a final note, as indicated at several instances above, the country-commissioned evaluations have tended to present a relatively less critical picture of HSS support as compared to the Gavi-commissioned evaluations. This may be a case of "optics", as the country-commissioned reports provide less information on grant management processes. However, in most of these instances, our findings gain robustness through support from the FCE and IRC reports.

3. RECOMMENDATIONS

This final section provides recommendations on Gavi’s approach to HSS support, drawing on the findings of the meta-review.

First, we provide an assessment of whether the issues identified in the 15 key findings presented in Section 2 have been addressed through modifications to Gavi’s approach to HSS over time. These are based on CEPA’s understanding of changes (past and ongoing) to Gavi HSS support as well as the HSS Guidelines over the years.

We then move on to our recommendations, which relate to the design, implementation and M&E of Gavi HSS support. We describe key issues that we recommend Gavi consider, although do not provide suggestions on “how” Gavi might implement these (an area that would require a detailed assessment in its own right).

Finally, we provide some suggestions on how Gavi might commission and manage end-of-grant evaluations of HSS support going forward. It is noted that our suggestions are based on “part of the picture” only, given that these are based on a review of the quality and content of the 14 HSS evaluation reports only.

3.1. Assessment of progress

Our findings from the meta-review have identified a number of issues with the design and implementation of Gavi support. Some of these are “directly controllable” by Gavi, and include issues such as:

- Lack of definition/ clarity of Gavi HSS support (key findings 1, 2, 6, 10, 11, 13, 15);
- Insufficient guidance, communication and support to countries (key findings 1, 2, 4, 5, 9, 10, 11, 15);
- Challenges with delivery model through a lean Secretariat and in-country Partners (key findings 4 and 9);
- Inappropriate/ ineffective M&E arrangements (key findings 11, 13).

Others relate to the fundamental challenge of weak government capacity and effective governance at the country level (key findings 1, 5, 6, 7, 10, 11), and while not directly controllable by Gavi, merit a re-think or renewed approach to ensure effectiveness of HSS support.

We understand that Gavi has been seeking to address these issues overtime through:

- Re-positioning or focusing its HSS window on immunisation outcomes through the PBF approach (rather than broad-based health systems), alongside greater specificity on types of activities supported by HSS through “grant activity categorisation” tables in the HSS

Guidelines from 2013 through to the reference to the Strategic Focus Areas (SFAs) in the 2016 Guidelines;

- Increase in the number of SCMs over the years for more detailed hand-holding of countries;
- Annual updates of application guidelines from 2013, to ensure countries are provided with up-to-date information, and with the most recent 2016 HSS guidelines in particular presenting a much more streamlined and focused guidance to countries (as compared to previous years);
- Discontinuation of the APR (recognising its various issues) and introduction of the Performance Framework as well as Joint Appraisals and the Partner Engagement Framework (PEF) for more “joint-up” and followed-through reviews;
- Importantly, Gavi is presently undertaking a review of its direct financial support, which includes HSS support, and will be looking to bring about several reforms.

Annex 8 provides details on progress made by Gavi by key finding.

However, we note that majority of our findings from the country HSS evaluation reports have been supported by the more recent FCE and IRC reports, thereby indicating that the issues have not been substantially or fully addressed. Further, several of the above-noted interventions have been recently developed/ introduced or are currently in development, and hence it would be important to understand their impact in circumventing the identified challenges. As such, it is our opinion, that while Gavi is presently making some changes, the key issues identified have not, per se, been addressed.

3.2. CEPA’s recommendations

Our recommendations, presented by order of priority and reflecting ongoing work (to the extent we are aware), are detailed below.

Recommendation 1: Gavi to critically consider key aspects of the scope and objectives of HSS support, as well as provide further definition in relation to those objectives.

Gavi has clearly sought to focus its HSS window over time on systems strengthening for improved immunisation delivery and outcomes (as per the refined wordings for its health systems goal over successive phases²⁸ and the introduction of the PBF approach wherein improved immunisation

²⁸ Gavi’s Strategic Goal 1 for 2007-10 was “to contribute to strengthening the capacity of the health system to deliver immunisation and other health services in a sustainable manner”. In June 2014 the Gavi Board further updated SG2 for 2016-20 to “increase effectiveness and efficiency of immunisation delivery as an integrated part of strengthened health systems”.

outcomes are rewarded with additional funding), however broader strategic issues remain with regards to the scope and objectives of its HSS window, including:

- How the increased immunisation focus ensures alignment with the overall health sector (as per the issue identified in IRC reviews of recent HSS proposals, under key finding 1).
- Although a country-specific issue, more generally, which health system bottlenecks are to be prioritised for Gavi HSS support, given Gavi's overall mandate.
- How to strike the appropriate balance between Gavi HSS funds representing a small proportion of funds for health systems in most countries and the intended *catalytic* and *value add* objectives of Gavi support (as stated in successive Guidelines for Gavi HSS support and as will become more relevant as part of the guiding principles for the Gavi 2016-20 strategy). Relevant issues include the difference between supporting health systems activities and those that "strengthen" the system and their longer term sustainability.

As such, in our assessment, whilst Gavi is clear on *what* HSS investments aim to achieve (i.e. improved immunisation outcomes), there is still a lack of clarity around *how* countries can achieve that impact. It is our recommendation therefore that Gavi considers whether its HSS window merits *further definition*, whilst retaining the country-driven and country-owned principle guiding the organisation as a whole.

We note that the ongoing DFS Steering Committee has recommended that HSS investments be prioritised around the four SFAs of supply chain, data, demand generation, and leadership, management and coordination, with the option to further specify investments within these areas. These efforts towards greater definition appear useful in our view, however they also raise the question again as to whether Gavi support in this area would constitute health or immunisation system support.

Recommendation 2: Gavi to provide complete information and improve clarity on its HSS window, requirements and processes for countries.

There have been several instances of lack of adequate information and clarity amongst countries on Gavi's objectives for HSS support (especially with the move from a broad health system approach to a narrower immunisation-focused approach) as well as key requirements and processes, both for application and during implementation and fund disbursement. Specifically, our main suggestions for greater information and clarity for countries would be on the following topics:

- Overall scope and objectives of Gavi HSS support (as per Recommendation 1 above);

- Timelines from proposal submission to approval to grant initiation and successive fund disbursements;
- Clarity on HSS grant “start” and “end” dates (i.e. does the HSS grant start at the time of approval or first fund disbursement and does it end at the time of last fund disbursement, completion of activities, final reporting, etc.);
- Requirements for stakeholder engagement during the proposal development process – who, how and why – specifically in terms of stakeholder groups that have not been adequately engaged appropriately such as CSOs, private sector, sub-national government representatives, etc.;²⁹
- Requirements for HSCC role during proposal development and grant implementation, including appropriate composition, ways of working, etc.;
- Clearer delineation of what is and is not acceptable to Gavi in terms of programme management practices, fund use, etc.;
- Requirements for financial and fiduciary management – both in general terms as applicable for all countries as well as clarity on the specific steps and processes for individual countries based on their individual circumstances;³⁰
- When and how the Secretariat and Partners are available to support countries during proposal development and grant implementation.

Gavi needs to evaluate the most appropriate mechanisms for providing this greater level of information and clarity to countries in a format most relevant to country needs, notwithstanding the frequent turnover in country governments. Options include improving existing mechanisms such as the application Guidelines and communications through Gavi Secretariat SCMs and in-country Partners, or developing new mechanisms such as developing a grant implementation handbook, amongst others.

²⁹ We note that the 2016 General Guidelines provide more details on the potential roles of different stakeholders in the application development process. It may be useful to consult with countries on whether this has served as adequate guidance or whether more is required (e.g. “best practice” examples from countries). There could also be a “checklist” for countries to conduct a “self-assessment” of the extent to which the application development process has been participatory in the application form, by way of understanding the strengths and weaknesses of the processes they have employed.

³⁰ We note the 2016 General Guidelines provide a discussion of financial management and audit requirements, however perhaps more is required in terms of ensuring that countries clearly understand these and that they address different scenarios that countries may find themselves in.

Recommendation 3: Gavi to consider the most appropriate delivery model for HSS support and whether a more “hands-on approach” may be required for select countries.

We understand that the delivery model for Gavi HSS support in terms of a “hands-off” approach, with support from in-country Partners complemented by “light touch” Secretariat input, has been chosen on account of a number of important and valid reasons (e.g. fostering country ownership, cost efficiency, etc.). However this meta-review has clearly shown the challenges with this delivery model for HSS support with: (i) most countries expecting and requesting more substantial and formal assistance, both in terms of technical guidance and information on Gavi’s requirements and processes; (ii) weak capacity and challenges with effective programmatic and financial management by countries; and (iii) lack of clarity of the roles and responsibilities of in-country Partners, including in terms of serving as Gavi representatives in country. As such, it would be important for Gavi to clarify expectations of in-country Partner roles, including ensuring that they are fully abreast of Gavi requirements (as perhaps is intended through the PEF).

We recommend that Gavi consider whether variations to its existing model may be appropriate, at least for select “problem” countries to ensure additional expertise or handholding for appropriate proposal development and grant governance, implementation and monitoring. This may include:

- At one extreme, enhanced Secretariat input/ presence at the country level (subject to an assessment of relative costs), or at the other, building on existing arrangements with in-country Partners. We note that Gavi SCM capacity has been increased over the years and there are plans to implement the PEF.
- A consideration of innovative ways to improve country capacity or leverage existing in-country arrangements. We understand that several initiatives are ongoing in terms of work under Gavi’s SFA on strengthening in-country leadership, management and coordination, Joint Appraisal process, etc. Other options include leveraging in-country capacity by providing funding through pooled donor funds.
- There may also be a case to develop more formal mechanisms to share best practice and lessons learned, particularly within regions, as also recommended by the DFS Steering Committee, who note this should be the joint responsibility of all Partners.

Recommendation 4: Gavi to critically assess how to mitigate implementation delays for HSS grants as well as consider key implications of these delays.

A key finding of this meta-review has been the pervasive delays in HSS grant implementation for a number of countries, thereby meriting a critical assessment by Gavi on how best to circumvent these delays. In addition, given the recent 2016 HSS guidance on the duration of HSS support

being for a minimum of 3 years and aligned with a country's cMYP, it is now even more critical that Gavi improve processes to avoid implementation delays.

While there is no “easy” recommendation for this, given the multitude of factors at play. We suggest that at the very least Gavi provides clear guidance to countries to ensure that HSS applications are started sufficiently in advance, flags over-ambitious timelines upon receipt of applications and manages country expectations around the timings of grant implementation including for fund disbursement, M&E requirements, etc. (as per some of the points noted in Recommendation 2). Further, Recommendation 3 on a more “hands-on” approach by Gavi for select countries would also support reductions in implementation delays.

We also suggest that Gavi consider key implications of the delays, such as the following:

- Given the new guidance on HSS support duration in relation to the cMYP, Gavi will need to consider implications of scenarios such as a country HSS application with less than three years remaining on a cMYP or significant HSS funding remaining on cMYP conclusion.
- To ensure that HSS grants continue to provide value for money, Gavi should conduct an analysis of the transaction costs and opportunity costs incurred as a result of the delays – by countries, the Gavi Secretariat and Partners.

Recommendation 5: Gavi to consider the appropriate monitoring of HSS grants and ensure a clear linkage between monitoring information and follow-up action.

The meta-review has highlighted a number of challenges with the monitoring of HSS grants under review, and as such, our recommendations are as follows:

- There is a need for greater focus on tracking process and output indicators, rather than outcomes and impacts which may not be directly linked with the HSS investments. There needs to be an appropriate balance in the monitoring approach in terms of tracking the priority (and possibly not all) indicators; clearly defining the data baseline, target and sources; and ensuring necessary updates over time, including with HSS reprogramming or reallocation.
- Gavi could be a “front-runner” in terms of endeavouring to measure the “system strengthening” impact of its HSS investments (both positive and negative). As described previously, Gavi HSS investments are leading to important “direct” and “indirect” system strengthening effects, which in our assessment, are not being captured and studied adequately.
- Finally, there needs to be a clear linkage between the monitoring information generated and appropriate follow-up actions to improve the efficiency and effectiveness of grants.

We note that the recent development of the Performance Frameworks aims to address some of these issues, although are unable to comment on the full scope of issues addressed by these Frameworks given their recent implementation. We also note the introduction of Joint Appraisals which may strengthen the linkage between monitoring and follow-up action.

As these are all recent developments at Gavi, it would be important to keep their effectiveness under close review to ensure that they are indeed adequately addressing the key challenges.

Recommendation 6: Where HSS funding is channelled through Partners greater clarity is required on processes and an “exit strategy” to support country capacity strengthening should be developed.

Our review of the country HSS evaluation reports found certain challenges with channelling funds through Partners (notwithstanding the benefits of improved management and accountability). As such, we recommend that certain processes are clarified further, and clearly communicated to countries, especially given the recent IRC report comments that this approach to fund channelling is on the rise and particularly relevant for post-conflict or fragile countries.

In particular, we recommend the following:

- greater clarity on roles and responsibilities of Partners, government ministries and Gavi Secretariat, including fund management requirements such as process and timelines for disbursements between the various parties involved and reporting requirements;
- specific guidance to avoid conflict of interest, both perceived and actual, where a Partner is acting as both fund manager and implementer; and
- development of an “exit strategy”, including a detailed assessment of government financial weaknesses and accompanying provision of capacity building support.

Recommendation 7: Gavi needs to proactively clarify and provide guidance on reprogramming and reallocating HSS funding.

This meta-review has clearly shown a lack of understanding across countries around reprogramming and reallocating HSS grants, with these terms being used synonymously in evaluation reports. Whilst additional guidance has been issued on these processes since many evaluations were conducted (for 2016), given the pervasive nature of this issue, Gavi needs to proactively address this point, through ensuring that:

- countries are aware that such guidance exists and when/ how to use it;
- Partners are fully informed of these processes and actively informing countries when it may be of relevance; and

- SCMs are actively engaged with country progress to highlight when such guidance may be required.

In addition, Gavi needs to proactively ensure that the newly implemented guidance around updating, supplementing and replacing activities and indicators in the Performance Framework during reprogramming is functioning effectively.

3.3. Suggestions on end-of-grant HSS evaluations

As specifically requested, we provide some thoughts on Gavi’s approach to end-of-grant evaluations of HSS support, given these are now a mandatory requirement for all HSS grants. **We strongly caveat our recommendation by stating that our suggestion is based only on the focus, content and quality of the evaluation reports included as part of this meta-review (discussed in detail in Annex 6), and we have not considered other important factors such as the relative costs and processes of these evaluations, availability of expertise in countries to conduct effective evaluations, amongst others.**

As previously stated in the report, there has been a difference in the focus, content and quality of the Gavi and country commissioned reports, as follows:

- *Focus and content:* The country-commissioned evaluations have been more in-depth in their assessment of progress and challenges in implementing HSS activities, and whether or how different/ additional strategies may be relevant for country implementation of those activities going forward. On the other hand, the Gavi-commissioned reports, have been stronger on issues relating to an assessment of the processes and management of the grants (in particular, Secretariat and Partner roles) and the contribution of Gavi support to the country;
- *Quality:* Majority of the country-commissioned evaluations have been rated as being of poor quality (although 2 of 6 are of good quality), while all of the Gavi-commissioned evaluations have been assessed as good quality.

As such, there are benefits of both approaches, albeit challenges with the quality of country-commissioned reports, and hence our suggestions on aspects for Gavi to consider are as follows:

- Conduct a more well-rounded assessment of other factors impacting evaluations (such as costs, expertise, etc.) and develop a comprehensive view and approach on how to manage end-of-grant evaluations;
- Potentially consider a Gavi or country commissioned approach on a case by case basis, rather than a pre-determined single approach;

- Engage closely with countries to encourage well-rounded and rigorous evaluations. Where capacity is particularly weak, Gavi may consider some additional hand-holding or support to facilitate effective evaluations; and
- Ensure that all evaluation TORs are jointly developed by the country and Gavi, with engagement of both parties in the evaluation report (as practically feasible) irrespective of the source of commissioning.

ANNEX 1: LIST OF REFERENCES

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ANNEX 2: ANALYTICAL AND CODING FRAMEWORK

Table A2.1: Analytical and coding framework for synthesis of findings in country HSS evaluation reports

Dimensions and issues	Coding
Relevance and alignment	
Relevance for countries (alignment with national health sector plan and country needs/ requirements; appropriateness of design)	Full/ Partial/ None
Alignment with Gavi HSS	Full/ Partial/ None
Complementarity with other in-country resources (at time of proposal)	Full/ Partial/ None
Support for IHP+ criteria	Full/ Partial/ None
Efficiency and effectiveness	
In-country proposal development process (involvement of all relevant stakeholders, role of Gavi and guidance provided by Gavi)	Fully participatory/ Partial / None
In-country programme management (performance of implementation modality, governance arrangements, work planning arrangements, reprogramming)	Highly effective/ Effective/ Improving/ Poor
In-country governance mechanisms (whether HSCC is in place and functional)	Highly effective/ Effective/ Improving/ Poor
In-country financial management (disbursement, spend and absorption issues)	Highly Effective/ Effective/ Improving/ Poor
Timeliness of implementation (adherence to implementation plan; delays and reasons for these)	Timely/ Slight delays / Significant delays
Monitoring and reporting (M&E framework, challenges)	Highly Effective/ Effective/ Improving/ Poor
Support from Gavi Secretariat and Partners (during proposal development, implementation and monitoring)	Full/ Partial/ None
Coordination with other donor funding (during implementation)	Full/ Partial/ None
Coordination between HSS and NVS	Full/ Partial/ None
Results/ impact	
Achievement of proposal objectives	Full/ Partial/ None
Improvements in immunisation services	Highly effective/ Effective/ Improving/ Poor
Impact on health systems	Highly effective/ Effective/ Improving/ Poor
Unintended consequences	Positive/ Negative/ Mixed
Sustainability	
Sustainability (existing evidence, potential)	Measures in place/ potential/ none

ANNEX 3: DETAILED REVIEW OF QUALITY OF REPORTS AND SUMMARY OF EVIDENCE

Please refer to the accompanying MS Excel file titled “*CEPA evidence base_Gavi HSS evaluations meta-review (final)*”.

ANNEX 4: COUNTRY CONTEXT FACTORS AND EVALUATION TYPE – CORRELATION WITH FINDINGS

To add further depth of analysis and ensure key findings take into consideration potential external influencing factors, we have included the following range of country context factors to the analytical and coding framework:³¹

- **Country income level** – using World Bank’s classification of countries based on estimates of gross national income (GNI) per capita, as follows:³²
 - *Low-income countries (LIC)*: US\$935 or less
 - *Lower middle income countries (LMIC)*: between US\$936 and US\$3,705
 - *Upper middle income countries (UMIC)*: between US\$3,706 and US\$11,455
- **WHO region** – WHO member states are grouped into six different regions, with AFRO, EMRO, EURO and SEARO represented in this sample of 14 countries.
- **Fragility status** – using Gavi’s 2008 New Vaccine co-financing Policy grouping of countries, which identified fragile countries as a separate category.
- **Total health expenditure (THE) per capita** – to enable a comparison by health system financing levels across countries. WHO estimates that a minimum of US\$44 is needed per person per year to provide basic, life-saving health services.³³ As per the methodology used in WHO’s Global Health Expenditure Atlas, 2014, we have categorised countries against two benchmarks of US\$20 and US\$44.
- **DTP3 coverage** – to enable a comparison of immunisation/ health systems across countries. As per Gavi eligibility criteria, we have categorised countries against two benchmarks of 70% and 90% coverage.

In addition, we have included details on the **type of evaluation report**, including Gavi- or country-commissioned; final or draft report; end of term or mid-term evaluation; and **whether the country had amended its HSS grant**, such as through reprogramming or reallocation.

We have conducted a basic correlation analysis of each of these factors and our findings to assess if there is any pattern/ trend. We note the following areas of correlation:

- **Reprogramming of HSS support** – There is correlation between HSS support being reprogrammed and elements of the relevance and alignment dimension being positively assessed, for example relevance for countries, alignment with Gavi HSS, complementarity

³¹ In order to compare country contexts prior to HSS support, we would use 2007 data.

³² <https://datahelpdesk.worldbank.org/knowledgebase/articles/378834-how-does-the-world-bank-classify-countries>

³³ WHO Global Health Expenditure Atlas, 2014 <http://www.who.int/health-accounts/atlas2014.pdf>

with other in-country resources, as well as correlation with poor in-country management. This correlation, as noted in key finding 8, highlights that countries increased alignment with Gavi HSS through reprogramming.

- **THE pp/year** - Correlation is seen between high THE pp/year and effective in country management, as well as low THE pp/year and lack of sustainability measures in place.
- **DTP3 coverage** – There is correlation between lower levels of DTP3 coverage and poor in-country programme and financial management.
- **Fragility status** - Correlation is noted between countries classified as not being fragile and showing a greater degree of support for IHP+ criteria. However, there is limited discussion around IHP+ criteria generally within the evaluation reports.
- **Evaluation type** – There is also correlation between Gavi-commissioned evaluations and a poor rating of elements in the efficiency and effectiveness dimension, as well as the results and impact dimension.
- **Quality of evidence** – Reports which have been rated as good quality are correlated with poor levels within the effectiveness and efficiency dimension, including for in-country programme management, in-country governance systems and in-country financial management. Further, correlation is seen between good quality reports and a poor rating of improvements in immunisation services and impact on health systems.

ANNEX 5: METHODOLOGICAL LIMITATIONS

The following limitations apply to the meta review. We also provide mitigating actions used by CEPA, where relevant.

- **Exclusive reliance on evaluation reports.** The source material for the meta-review is limited to the evaluation report for each of the 14 countries. There is no provision to collect additional information or clarify the context/ discussions supporting the report findings and recommendations. This is challenging at times as:
 - the reports make assertions or present findings without an adequate evidence-base (and as such, at times, we have had to accept certain assertions made in the report, even if the evidence-base is not viewed as sufficient).
 - there is ambiguity in some of the presentation – e.g. reference to Gavi without clarity on whether this indicates the Alliance as a whole, the Secretariat or Partners (and as such, at times, we have made some assumptions on the conclusions being presented).
 - not all aspects of the meta-review ToR are covered by the reports (e.g. support for IHP+ criteria, coordination between Gavi HSS and NVS support).

As such, the level of available information, as well as the quality and robustness of findings and conclusions for the meta-review are dependent on the content, quality and robustness of each of the country evaluations. CEPA's broad-based understanding of the functioning of the health systems in many of the focus countries and Gavi's HSS window has helped better understand and interpret some of the findings.

- **Element of judgement in qualitative analysis.** The synthesis and robustness assessment in the meta-review inevitably involves a degree of judgement from the team members. However, we have clearly document the process and analytical framework and conducted cross-checks by the team members to ensure consistency.
- **Potential bias between types of evaluation.** The country evaluations included in the meta-review have been undertaken prior to evaluations becoming a mandatory requirement. As such there may be some bias in the underlying reason for conducting the evaluation. We note in particular from the ToRs that country-commissioned evaluations were conducted where countries expressed a strong interest for reviews of previous grants to inform subsequent applications; such evaluations may therefore be less critical of country HSS progress or Gavi support. Countries for Gavi-commissioned evaluations were chosen due to experiences considered to be of particular interest to Gavi; and as such these issues are likely to be the focus of the evaluation. This potential bias has been taken into consideration when assessing each evaluation.

- **Limitations of robustness assessment through use of IRC and FCE reports.** Specifically:
 - The IRC reports do not comment on the implementation and results of the Gavi HSS grants.
 - The IRC and FCE reports cover Gavi HSS grants over a different time period when the HSS window has undergone significant changes. As such, some of the findings from the 14 evaluation reports is not covered or contradicts these other reports, thereby impacting the robustness assessment.
 - The FCE reports are prospective in nature, therefore provide limited information on overall achievement of activities, with several of the HSS grants in their early implementation stages.

ANNEX 6: REVIEW OF GAVI VS. COUNTRY COMMISSIONED EVALUATIONS

The study includes eight evaluations commissioned by Gavi to understand particular experiences of countries and six evaluations commissioned by countries to inform subsequent applications. The difference in who has commissioned the evaluation and the basic objective for commissioning has resulted in a degree of variance in the scope, content and quality of the reports. This annex presents a discussion on the differences between the two types of reports, in terms of both the ToR and evaluation reports.

Terms of Reference

We have reviewed the available ToRs of the Gavi and country commissioned HSS evaluations and provide key points by way of a comparison. ToRs are available for all eight Gavi-commissioned evaluations and 4 of the 6 country-commissioned evaluations.³⁴ Our comments are as follows:

Scope/ content

In general, all evaluation ToR have a similar scope in terms of a review of the design, relevance, implementation, efficiency, results and sustainability of Gavi HSS funding, although the emphasis on each of these aspects varies by evaluation. Notably:

- The country-commissioned ToRs have focused less on process and management issues (both during proposal development and grant implementation, apart from issues relating to fund management), but more so results (i.e. whether the HSS grant led to improvements in the health systems and outcomes). Specifically, the ToRs consider implementation challenges, but they do not emphasise a review of the functioning and performance of the various institutions/ stakeholders involved such as the structure/ unit for programme management in country, the HSCC, Gavi Secretariat and Partner roles, etc. The results-focus is evident from the detailed questions encompassing issues such as whether alternate strategies should be employed for achieving certain results and the ultimate outputs, outcomes and impact of the support. This is particularly evident in the ToRs for the Yemen evaluation, but less so in the ToRs for Sudan.
- Some of the country-commissioned ToRs also do not consider questions around relevance and alignment with country needs and Gavi HSS objectives, appropriateness of the design of the grant, etc.
- The Gavi-commissioned ToRs aim to understand the specific role and contribution of Gavi with questions focusing on the role of the Secretariat and Partners, contribution of the Gavi-required HSCC for HSS applications, and whether Gavi HSS support has been

³⁴ ToRs are not available for Eritrea or Myanmar.

catalytic, complementary, amongst others. Several ToRs also specifically note that Gavi has commissioned the evaluation in coordination with the Ministry of Health.

- We also note a trend on the extent to which Gavi-commissioned ToRs include questions about the impact of results. Some of the earlier evaluations include much broader questions about the extent to which HSS programme has contributed to under-five child mortality (e.g. Burkina Faso, Ethiopia), whereas later commissioned evaluations focus only on contribution to increased immunisation outcomes (e.g. Nepal, Tajikistan, Somalia) or simply the extent to which programmatic results have been achieved (e.g. Cameroon, Madagascar, Chad).

Structure and clarity

The ToR for Gavi-commissioned evaluations are much clearer, with the ToR following a more systematic and consistent structure in terms of how specific questions are formulated and categorised according to key evaluation criteria (design, implementation, efficiency, results, sustainability and lessons learned), as well as providing clear advice on the expected methodology. This semi-standardised structure is then adjusted to the country context, to pick up specific issues such as reprogramming and programme suspension, and to address what we have been informed as being Gavi's aim for the evaluation – e.g. to understand the relative effectiveness and efficiency of channelling funds through Partners in Burkina Faso and Chad.

In comparison, the ToRs for the country-commissioned evaluations are less clear, in that

- The questions are not set out precisely and often poorly formulated – e.g. Sudan ToR (country-commissioned) – *To what extent were activities implemented?* vs. for Nepal ToR (Gavi-commissioned) – *To what extent have the activities included in the GAVI HSS grant application been implemented as planned?*
- The questions are often presented at a high-level with many sub-questions/ evaluation sub-components not detailed e.g. the Yemen & Sudan ToR.
- The questions are repetitive – e.g. the Afghanistan ToR includes close to 60 questions, with duplication over many questions – *What contextual factors critically influenced the implementation of activities either positively or negatively?* and *What factors including social, economical and cultural hindered or facilitated the implementation of different components under GAVI support?* Similarly with Yemen, the questions around implementation effectiveness, impact and request for recommendations are repetitive and as such quite confusingly presented.
- Different evaluation criteria are lumped together in the questions – e.g. for Sudan, *What is the value added by GAVI HSS grant compared to other funding sources? What were the positive and negative consequences (intended and unintended) of GAVI/HSS project?*

Specific questions covered in some ToR

Some ToR (Gavi and country-commissioned) include specific questions which we view as interesting and relevant (also given the findings from this review) and may be considered more often or as standard practise in country HSS evaluation ToR:

- whether proposal design sufficiently accounted for country context (e.g. Somalia & Cameroon– *To what extent did Somalia’s HSS application take in consideration the country political and security contexts? To what extent the HSS application was based on a realistic assessment of country ability to implement the programme, particularly in relation to human resources?*)
- whether proposal design was based on a clear theory of change showing solid links between planned activities and health system strengthening, in particular improved vaccination coverage (e.g. Madagascar, Chad, Cameroon, Burkina Faso)
- explicit question around the involvement of CSOs in design and implementation, given the findings in some evaluations that this stakeholder group has been marginalised (e.g. Ethiopia – *To what extent were Civil Society Organisations (CSOs) actively involved in the design of the application?*)
- whether feedback from monitoring has been acted upon (e.g. Ghana & Ethiopia - *To what extent was the feedback received useful and led to appropriate actions?*)
- questions around the complementary and catalytic nature of the funds (e.g. Ghana & Ethiopia - *To what extent were GAVI’s HSS funds catalytic to other funding sources in the health sector?; To what extent were GAVI’s HSS funds complementary to other funding sources in the health sector?*)
- specific questions on sustainability to encourage a review of relevant topics such as the distinction between programmatic and financial sustainability (e.g. Ghana & Ethiopia – *To what extent has the training supported by the HSS programme been integrated into the country’s routine health workforce training programmes? To what extent has turnover of trained staff affected sustainability?* The question is even more specific in the Tajikistan ToR – *To what extent, can each of the intervention tested in GAVI funds (mobile team, incentive scheme, etc.) be sustained or scaled up without HSS support, taking into account the projected fiscal space of the government and other available donor funds in near future*)
- whether previous studies/ evaluations or feedback from Gavi/ Partners were used and were useful in designing the follow-on HSS support (e.g. Madagascar, Chad)

Evaluation report

We provide a summary review of the key differences between the evaluation reports in terms of content and quality:

Content of evaluation report

Country-commissioned evaluations provide greater emphasis on results, such as whether the HSS grant led to improvements, as compared to grant process and management issues, with a notable lack of information on relevance/ alignment with country needs and Gavi HSS objectives. In contrast, Gavi-commissioned reports focus on evaluating the specific role and contribution of Gavi and whether Gavi HSS support has been catalytic and complementary. These reports are also much clearer on grant management and related issues (including on Secretariat and Partner roles and performance).

Another key difference is the tendency of Gavi-commissioned evaluations to be more critical of certain dimensions than country-commissioned evaluations. A correlation analysis (discussed in Annex 4) shows an association between Gavi-commissioned evaluations and dimensions of efficiency and effectiveness being rated as poor, including in-country programme management, in-country governance mechanisms and in-country financial mechanisms. Further correlation is found between Gavi-commissioned evaluations and poor ratings within the results and impact dimension, specifically relating to poor improvements in immunisation services and limited impact on health systems. This correlation has been noted in several key findings and is also reflective of the comparison of Gavi- and country-commissioned evaluation ToRs, with the former providing a greater focus on process and management issues.

Quality of evaluation report

Based on the methodology described in Section 1.2, our assessment rates all of the Gavi-commissioned reports as being of good quality, while most of the country-commissioned reports are of poor quality, except for the Afghanistan and Myanmar reports. This conclusion may not be surprising, given we would expect Gavi to have stringent quality requirements for its reports. However we would also caution against too much emphasis on this dichotomy as the Gavi-commissioned evaluations have been more well-rounded in their coverage of issues and better understand the nature/ structure of Gavi HSS support, thereby serving as more relevant for this meta-review.

ANNEX 7: SUMMARY MATRIX ON ROBUSTNESS OF FINDINGS

Table A7.1: Key Findings and robustness rating

Key Finding	Robustness rating	Explanation	
Relevance and alignment			
1	Gavi HSS support to countries has been well-aligned with their health sector policies and plans, however weak country planning capacity has implied that several grants have not been designed effectively, thereby somewhat diluting their relevance.	Strong	Of the 13 evaluations that discuss alignment with country plans, 12 indicate alignment, of which 8 reports are rated as being of good quality. There is an almost balanced finding on the issue of good versus poor grant design, with 6 of the 13 reports supporting the latter view (majority of which are rated as being of good quality). The FCE and IRC reports do not fully support this finding on account of the changing focus of Gavi HSS support from Phases II-III, and hence does not impact our robustness rating.
2	In terms of adherence with Gavi's mandate, there has been wide variation in the interpretation of Gavi HSS support, with countries generally being unclear on Gavi's scope and objectives for the HSS window.	Good	Majority of the evaluation reports do not explicitly discuss this issue and hence we have endeavoured to reach a conclusion based on the stated objectives of the grants and broader discussions in the evaluation reports. 3 reports provide a more detailed review of this issue, all of which are rated as being of good quality. Key finding of 2015 FCE, enhancing robustness.
3	Gavi HSS funds have been coordinated with and complemented other donor funds in countries, especially where HSS funds have been channelled through country pooled funds.	Limited	9 evaluation reports provide information on coordination by design (i.e. as per the proposal) and 10 reports also comment on coordination during implementation. Majority of these reports suggest good or partial coordination, however details are very limited/ lack evidence, and hence the overall robustness rating has been marked down. Further, we note that the sample of pooled fund countries is only 2. One FCE report supports this finding.
Efficiency and effectiveness			
4	The proposal development process has been somewhat participatory, although often lacking CSOs, and concerns have been raised on representation and adequate guidance	Strong	10 country HSS evaluations discuss this issue, 7 of which are rated good quality. The March and June 2015 IRC reports as well as the 2014 and 2015 FCE reports corroborate majority of the findings.

Key Finding	Robustness rating	Explanation
from the Gavi Secretariat and Alliance Partners.		
5 Country programme management has been poor, primarily on account of weak country capacity coupled with poor planning.	Strong	Discussed in 12 country reports (9 rated good quality), none of which suggest well-functioning or highly effective programme management. 2014 and 2015 FCE reports describe similar and additional challenges.
6 Country HSCCs have generally functioned as intended during the proposal stage. However, they have not functioned well during grant implementation.	Good/Limited	Supported by 11 reports, 8 of which are rated good quality; however often reports do not provide much detail. The March 2015 IRC report does not fully support this finding on account of some changes in Gavi HSS support from Phases II-III, and hence does not impact our robustness rating.
7 Country financial management capacity and procedures have been weak, and coupled with poor programme management, have resulted in low absorption and delayed disbursements. Gavi's FMA requirements have increased complexity and added to delays.	Good/Limited	Supported by 8 country evaluations, 7 of which rated good quality. 2014 and 2015 FCE reports support some findings, while the June 2015 IRC report contradicts some findings.
8 Whilst reprogramming of country grants has resulted in greater relevance for countries and increased immunisation focus, there is a general lack of understanding of this process at the country level and significant transaction costs have been incurred.	Good	Of the 9 countries which reprogrammed, most reports present a reasonable level of detail on the reprogramming experience and have been rated as being of good quality. 2014 and 2015 FCE reports provide some information.
9 Gavi's model of delivery for HSS in terms of guidance and support from the Secretariat and Partners has not functioned effectively. There is a need and request from countries for a more "hands-on" model.	Strong	10 country evaluations discuss this issue, 8 of which rated good quality; 3 reports in particular site considerable challenges. 2014 and 2015 FCE Reports and March 2015 IRC report support finding.

Key Finding		Robustness rating	Explanation
10	Gavi HSS grants have experienced substantial delays in implementation.	Strong	This is a fact, in that 12 of 13 evaluation reports which provide information on this indicate delays, with there being significant delays for 11 countries. Key finding of 2014 and 2015 FCE Reports.
11	Monitoring and reporting systems are not functioning effectively, largely due to poor design at proposal stage.	Strong	Of the 12 evaluations which discuss monitoring and reporting, none conclude these systems to be highly effective or effective, with 8 concluding poor systems, of which 7 reports are rated as being of good quality. March and June 2015 IRC Reports as well as the 2015 FCE Report provide support.
Results and impact			
12	Proposed activities have, for the most part, been completed.	Good/Limited	Of the 12 evaluations which discuss whether planned activities have been completed, 6 provide a detailed review, of which 5 are rated as being of good quality. Limited information in 2014 & 2015 FCE reports.
13	There have been improvements in immunisation and health outcomes in most countries, but it is difficult to attribute this to Gavi HSS support.	Limited/Poor	Of the 12 evaluations which discuss immunisation and health outcomes, 8 evaluate that some progress has been made, 5 of which are rated as being of good quality. All reports note challenges with attribution to Gavi funding. Supported by 2015 FCE report findings.
14	There is emerging evidence of Gavi HSS support contributing to health systems strengthening.	Good/ Limited	Of the 13 evaluations which discuss health systems results, 7 evaluate that some progress has been made, of which 5 are rated as being of good quality.
Sustainability			
15	There is some evidence of Gavi HSS activities being sustained or there being potential to sustain after the completion of funding, but for the most part, potential for financial sustainability is weak.	Good/Limited	12 evaluations provide a review of sustainability (of which 8 are rated as being of good quality). The assessment is not in-depth and detailed. There have also been different perspectives on how financial sustainability is to be assessed ranging from a general overview of the trends in government budgets for health and immunisations to a specific discussion on key activities supported under the HSS grant. The 2015 FCE report supports the finding.

ANNEX 8: ASSESSMENT OF PROGRESS BY GAVI ON IDENTIFIED ISSUES

The table below provides a summary of key interventions and improvements in the HSS Guidelines contributing towards addressing the key issues identified in this meta-review. As described in the main body of the report, it is our opinion, that while Gavi is presently making some changes, the key issues identified have not, per se, been addressed.

We also note that while the 2016 HSS Guidelines include information relating to some of the identified challenges, it is beyond our scope to assess if the improved guidance adequately addresses the identified issues, and also that these represent only one channel for guidance to countries (alongside, for example, SCM communication, amongst others)

Table 8.1: Key findings and assessment of progress

Key Finding	Modifications to HSS support/ improvements to Guidelines
<p>1 Gavi HSS support to countries has been well-aligned with their health sector policies and plans, however weak country planning capacity has implied that several grants have not been designed effectively, thereby somewhat diluting their relevance.</p>	<ul style="list-style-type: none"> • Gavi has recently introduced a Joint Appraisal (JA) process which will help countries plan for future applications. • The successive guidelines over the years have aimed to provide additional information to assist countries in developing better applications to Gavi, with the most recent 2016 HSS guidelines being more streamlined and encouraging countries to think through the “bottleneck analysis” (e.g. Section 5.2). A budget and gap analysis template and guidance has also been provided.
<p>2 In terms of adherence with Gavi’s mandate, there has been wide variation in the interpretation of Gavi HSS support, with countries generally being unclear on Gavi’s scope and objectives for the HSS window.</p>	<ul style="list-style-type: none"> • Introduction of PBF approach since 2012 and greater specificity of Gavi’s Strategic Goal 2. • Introduction of the SFAs as part of Gavi Phase IV strategy. • Introduction of “grant activity categorisation” tables in the HSS Guidelines from 2013 through to the reference to the SFAs in the 2016 Guidelines
<p>3 Gavi HSS funds have been coordinated with and complemented other donor funds in countries, especially where HSS funds have been channelled through country pooled funds.</p>	<ul style="list-style-type: none"> • The 2016 HSS Guidelines require a budget gap analysis to be conducted as part of the proposal, in order to ensure complementarity with other funding sources.

Key Finding	Modifications to HSS support/ improvements to Guidelines
<p>4 The proposal development process has been somewhat participatory, although often lacking CSOs, and concerns have been raised on representation and adequate guidance from the Gavi Secretariat and Alliance Partners.</p>	<ul style="list-style-type: none"> • The 2016 General Guidelines provide more details on the range and role of partners to be involved (Section 4.2).
<p>5 Country programme management has been poor, primarily on account of weak country capacity coupled with poor planning.</p>	<ul style="list-style-type: none"> • Gavi is aiming to support improved country programme management through several interventions such as enhancing SCM capacity, PEF, JAs, etc. • We also understand that some initiatives are ongoing in terms of work under Gavi's SFA on strengthening in-country leadership, management and coordination.
<p>6 Country HSCCs have generally functioned as intended during the proposal stage. However, they have not functioned well during grant implementation.</p>	<ul style="list-style-type: none"> •
<p>7 Country financial management capacity and procedures have been weak, and coupled with poor programme management, have resulted in low absorption and delayed disbursements. Gavi's FMA requirements have increased complexity and added to delays.</p>	<ul style="list-style-type: none"> •
<p>8 Whilst reprogramming of country grants has resulted in greater relevance for countries and increased immunisation focus, there is a general lack of understanding of this process at the country level and significant transaction costs have been incurred.</p>	<ul style="list-style-type: none"> • The 2016 HSS guidelines have been revised to better present the reallocation and reprogramming options and the differences between them.

Key Finding		Modifications to HSS support/ improvements to Guidelines
9	Gavi's model of delivery for HSS in terms of guidance and support from the Secretariat and Partners has not functioned effectively. There is a need and request from countries for a more "hands-on" model.	<ul style="list-style-type: none"> • We understand that the number of SCMs has been expanded over the years and there are plans for more hands-on support through the PEF.
10	Gavi HSS grants have experienced substantial delays in implementation.	<ul style="list-style-type: none"> • The DFS report notes that the Secretariat is working to improve delays through developing clearer recommendations from the IRC and better target in-country technical assistance to the most significant bottlenecks.
11	Monitoring and reporting systems are not functioning effectively, largely due to poor design at proposal stage.	<ul style="list-style-type: none"> • The introduction of Performance Frameworks and JAs are aimed at improve country monitoring. • Gavi has discontinued the APR system from 2015
12	Proposed activities have, for the most part, been completed.	
13	There have been improvements in immunisation and health outcomes in most countries, but it is difficult to attribute this to Gavi HSS support.	
14	There is emerging evidence of Gavi HSS support contributing to health systems strengthening.	
15	There is some evidence of Gavi HSS activities being sustained or there being potential to sustain after the completion of funding, but for the most part, potential for financial sustainability is weak.	