EVALUATION REPORT

BURKINA FASO

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# EVALUATION OF GAVI SUPPORT TO HEALTH SYSTEM STRENGTHENING IN BURKINA FASO


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# SUMMARY

## MANDATEAND METHODS

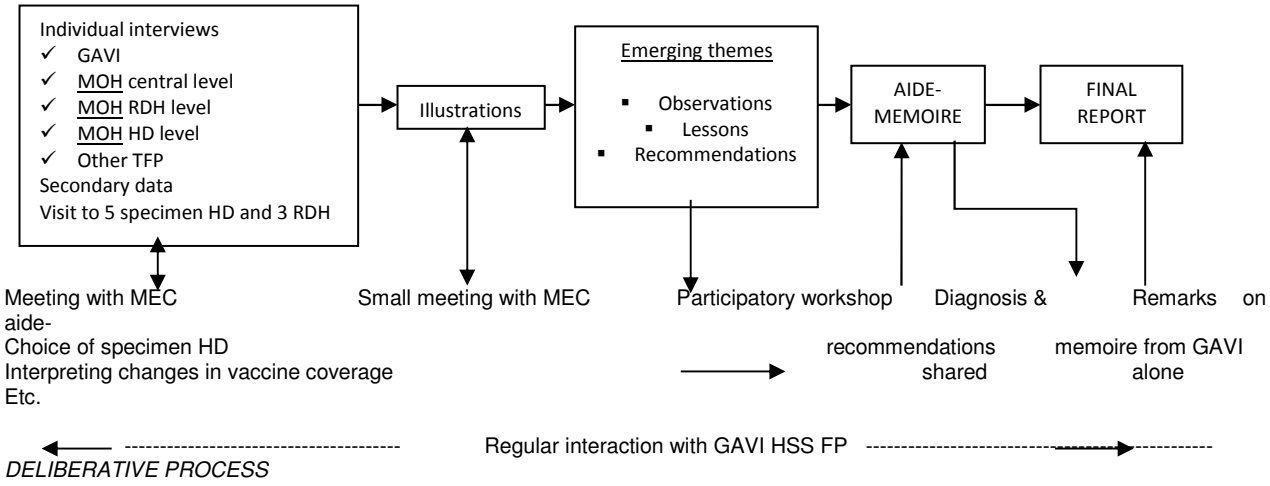
The mandate concerns the evaluation of GAVI support for health system strengthening in Burkina Faso focusing on the different steps of the intervention: preparation of the application, submission of the application to GAVI, execution of activities, preparation and submission of annual reports and monitoring of results. The evaluation covers the period 2008-2012 for GAVI-HSS funding, including all activities conducted in 2013 using the same funds.

The initial terms of reference for the evaluation covered a broad spectrum: analysis of relevance of the implementation, effectiveness and efficiency of results and impact and sustainability. They were redefined on mutual agreement to account for the constraints in time and resources, by stressing on lessons to be learned from design and implementation of GAVI-HSS and a lesser emphasis on utilizing intervention resources.

The methodology relies on a Quality-Quantity mixed design. The level of analysis alternates between macro components (national), meso components (districts) and micro components (HSPC or communities). With the consent of the study's sponsors, quantitative analyses were narrowed down to specific target districts earmarked as specimens for district-level intervention.

The evaluation team adopted a participatory approach by involving the evaluation stakeholders at every step of the process and especially in interpreting and validating its preliminary results. The process is illustrated in the figure below.

A graphic presentation of the process followed by the evaluation team:




Data was collected, processed and analysed between November 2013 and March 2014. Visits were made to five specimen districts and three Regional Directorates of Health (RDH) selected among the specimen districts. Specimen districts were selected on the basis of their exposure to GAVI-HSS activities.

- Sixty-two interviews were conducted including 16 with people from the central level of the Ministry of Health (MOH), GAVI and other technical and financial partners. Some key MOH informers were met several times to get a deeper insight into the target questions raised, including 18 interviews with people at regional level and 28 interviews with people at provincial level.

- Statistical data used was taken from the National Health Information System (NHIS).
- Documentary sources are varied: GAVI, MOH directorates, districts, health centres, etc. They specifically include Annual Progress Reports submitted by the Ministry of Health to GAVI and remarks, reactions or suggestions of the Independent Review Committee (IRC) and the GAVI team.

## OBSERVATIONS

### 1. GAVI HSS Intervention in Burkina Faso

**There are 5 areas of intervention:** (i) improve organization and management of health services; (ii) develop human resources in the health industry; (iii) strengthen community mobilization and social marketing in areas where the rate of utilization of health services is low; (iv) improve infrastructure, equipment and maintenance of the system; (v) strengthen basic infrastructure and equipment in the least serviced areas. These areas of intervention are divided into 44 main activities or group of activities.

### 1. Relevance analysis

1. The intervention falls under actions taken to strengthen the health system with GAVI's support. Its aim is to improve and maintain a high level of vaccine coverage in the country by making the health system more capable in providing immunization services and other health services, particularly those intended for mother and child.

2. Principles of alignment were respected. Processes related to situational analysis, evaluation of requirements, possible solutions, strategic and operational choices, priority intervention sites and duration of the program were steered by the national party. The Ministry of Health entrusted the financial management of the project to HDSP, and its coordination, monitoring and control to monitoring committee NHDP acting as Health Sector Coordination Committee (HSCC). This choice is in sync with the institutional arrangements agreed upon with the partners.

3. The national party mostly viewed GAVI-HSS as a financial mechanism aiming to fulfil the unsatisfied needs requiring quick action. The program choices take systemic needs into account and falls under the country's National Health Policy (NHDP 2001-2010). They are in line with the national strategic guidelines.

4. However, the stakeholders perceive GAVI-HSS differently. GAVI has a precise vision of its approach to health system strengthening and the place of HSS mechanism in the array of interventions supported by the organization. But local stakeholders – particularly at the peripheral level – do not take this situation in the right sense. There is a further lack of understanding given that the link with immunization is not always retained, the link with other components of GAVI intervention in Burkina is very limited, and the idea in itself is not well grasped by the national stakeholders.

5. GAVI-HSS had an overall target to fulfil needs and clear the bottlenecks limiting the capability to take action in the health system. But, the intervention does not target *exclusively* the "priority obstacles that hamper successful completion of immunization and other interventions related to maternal and child health" appearing in the GAVI-HSS guidelines 2007. There is always a possibility of a link with immunization activities although activities are not specific to those.

6. Considering that intervention is mainly based on the solution to structural and circumstantial bottlenecks, it can marginally be linked to the change theory centred on immunization.

7. Intervention is marked by a huge diversity in activities, which gives it its relatively fragmented character. Resources allocated to different areas of intervention are variable. Two areas, that is, "Improve organization and management of health services" and "Reinforce basic infrastructure and equipment in the least served areas" absorb two-thirds of the budget. Activities that gain from the highest allocations are related to construction of health centres and their functioning.

8. Progress indicators are consistent with the main objectives and activities of the application. But they are not sufficiently sensitive to change nor specific to the intervention.

## 2. Analysis of the process

The Board of Directors of GAVI Alliance and GAVI Fund accepted the application on June 26, 2008[1]; funds were received in September 2008 and implementation eventually started in 2009.

### Accuracy of implementation

1. There is high level of accuracy in implementation at local level, i.e., in regions and districts. Most activities were successfully completed.

2. Activities that show the highest degree of completeness and accuracy are those that fall under the routine annual program of the districts. Integrating GAVI-HSS activities in district programs reduces risks and proved an opportune strategy. Activities that were delayed and not completely executed were mostly those at central level.

3. The shortage in facilities is mostly related to two groups of activities: monitoring of intervention, and constructing and equipping health centres. This shortfall mainly results from inadequate construction management and a lack of foresight in requirements and constraints related to building and equipping the premises.

4. Stakeholders did not fully grasp the complexity of the construction activity. The team feels that the problem does not lie with the Ministry's capability to develop the infrastructure and manage the process of building and equipping health centres. Instead, there are limitations in the capability of the bodies in charge of GAVI-HSS project management to assume such responsibility, and in their expertise to execute such construction and equipping projects.

### Organization, management and monitoring of activities

1. Division of roles and responsibilities among the ministerial departments responsible for implementation (DGSSS) and HDSP was not clearly defined, before or during the implementation.

2. GAVI-HSS's intervention suffered from the absence of an unequivocal decision-making centre and a comprehensible and recognized leadership within the Ministry of Health.

[1] GAVI Alliance: Decision letter on the health system-strengthening proposal to the Ministry of Health on August 14, 2008.

3. GAVI-HSS functioned independently from the Directorate of Prevention through Immunization and thus independently from the other components of GAVI intervention that were placed under this directorate.

4. The implementation mechanism helped ensure successful execution and monitoring of tasks at peripheral level and of activities requiring minimal management. However, this mechanism proved to be ineffective in managing complex and costly activities like construction.

5. The intervention design is based on the multi-year operational program. This program is very detailed and includes identifying activities to be conducted, task groups and funds required for these different activities. This technocratic planning model lacks flexibility in terms of the objectives pursued that are focused on resolving bottlenecks. The process leaves little or no room for flexibility to operate based on the initiatives taken by the stakeholders in the region or district. It does not encourage quick adaptation to needs or new bottlenecks encountered in the course of implementation.

6. General responsiveness was greatly restricted through the absence of a management unit and regular monitoring of progress of the activities. In this context, the annual reporting system also revealed its limitations, as illustrated by the example on constructions.

Resource utilization

1. Almost all activities under the responsibility of health regions and health districts were completed between 2009 and 2010. The rate of resource absorption was almost 100%.

2. The deficit in resource utilization at the end of the year 2012 was 32% of the funds allocated to the intervention (US$ 1,599,340). It was mainly due to accumulated delays in activities placed under the responsibility of the central level, such as the completion of construction of the centres, provision of basic infrastructure, and monitoring intervention.

3. Although GAVI showed a constant effort to reschedule disbursements, the Ministry of Health was eventually unsuccessful in absorbing these resources. An analysis based on an approach on malfunctions reveals that difficulties faced in using the funds stem from its different points of contact with the planning process, the decision-making process, and administrative procedures.

4. Poor management of difficulties faced and non-completion of the project illustrate the lack of project coordination. In the opinion of the stakeholders, these difficulties could not find a suitable ground where they could be presented, discussed and analysed. The mechanisms responsible for “escalating” them to the decision-making bodies did not function properly.

5. The overall impression is that HDSP and DGSSS worked in “isolation”, such that the Health Sector Coordination Committee (HSCC) did not play its role effectively: no specific recommendation was made to GAVI-HSS after validating the reports and before sending them to GAVI.

Participation of GAVI and other Technical and Financial Partners

1. GAVI-HSS plays an important place in interactions between GAVI and the Ministry of Health in Burkina Faso.

2. GAVI fulfilled its commitment of monitoring the intervention. The process largely relies in examining the annual reports (APR). It is possible that this mechanism does not allow real-time corrective action to be taken or strengthening to be carried out.

3. Partners participated in the formal processes, which gave GAVI-HSS monitoring its rhythm year after year. The GAVI-HSS evaluation team however, does not have factual details showing their concrete or active involvement in implementation activities concerning various areas of intervention or intervention management.

## 4. Results analysis

HSS covers a wide array of activities sharing a common characteristic of fulfilling bottleneck-related needs. Thus, intervention cannot cover all action mechanisms influencing vaccine coverage. An analysis of GAVI-HSS impacts should be considered in the light of this reality and the restrictions that it imposes on the results chain. If the outcomes are measurable, focusing the intervention on a few bottlenecks and fragmenting and dissipating activities restricts the possible measurable effects on the health system, the performance of the immunization sub-sector, or the survival of target populations. As a result, links among outcomes, effects and impacts are of the nature of an intervention, too controlled to nourish the robust change theory for evaluation purposes.

For want of being able to provide proof of effects and impacts of the program, the analysis focused on the stakeholders' perception about the value added by GAVI-HSS and the study on the change in vaccine coverage in the intervention target districts.

1. On the whole, therefore, the stakeholders had a favourable feedback on GAVI-HSS.

2. There is no consensus on the level of health pyramid that benefited the most from GAVI-HSS contribution. Interviews suggest that it is at peripheral level that its added value will be most tangibly felt following the construction of health centres, acquisition of transport and initiatives including awards for the most efficient HSPC. For stakeholders at peripheral level, GAVI's main contribution was an increase in the services provided, an increase in the health cover, and stronger functioning of health districts.

3. The main reservation expressed by stakeholders at peripheral level concerned a lack of flexibility in the program that did not allow a customized solution specific to the needs of the districts.

4. The change in immunization activities for each of the antigens during the observation period 2006-2012 at national level and in specimen districts confirm, if required, improvements in vaccine coverage in Burkina Faso. This improvement is attributable to all mechanisms and actions taken by the national authorities with the support of the partners.

5. As stated, we do not observe a unique trend in the specimen districts compared with districts not involved in GAVI-HSS local interventions. Overall, their trajectories can be compared to those of other districts and it is not possible to differentiate the changes attributable to GAVI-HSS after its implementation, nationally or locally.

6. This does not necessarily mean that GAVI-HSS did not have any positive impact on the concerned districts. Stakeholders – as we saw – appreciated the actions taken. But the latter do not result in any measurable changes in the vaccine coverage as indicated in the evaluation study and the intervention theory analysis. It is possible that an intense strategy for a less fragmented health system strengthening (HSS) focused on immunization and rightly implemented and executed over an extended period of time could show measurable results.

7. In the given circumstances, the team decided that the modest potential theoretical effects rendered detailed statistical investigations pointless.

## LESSONS LEARNED AND RECOMMENDATIONS (REPRODUCED IN EXTENSO)

### 1. Lessons learned

From preparation of the GAVI-HSS application

1. The Ministry of Health was able to create an "atypical" program with an unusual format, involving several Government directorates and programs, although initial involvement of stakeholders from the peripheral level would have been more significant.

2. The program is aligned with the national health policy. Activities conducted at the peripheral level largely fall under the district action plan. This high level of integration was decisive; it led to a good level of accuracy in implementing activities at peripheral level.

3. Targeting bottlenecks and systemic needs is convincing; it corresponds to real needs and continues to remain a part of instructions formulated by the GAVI Alliance partner.

4. Efforts to identify (application) bottlenecks in the health system related to a classically vertical program (immunization) and even the deliberation process involved throughout the current evaluation proved an opportunity to strengthen the debate within the MOH on the concept of HSS, a theoretically well-known concept but with little operationalization. Implementation of GAVI-HSS2, which was largely inspired by the limitations observed in this aspect, will definitely constitute progress made in the general problems faced in operationalizing the HSS concept in Burkina Faso.

5. With GAVI's preference, the intervention was not positioned as an autonomous project. Its financial management was under HDSP and its technical coordination and use of the health information system was under the Directorate of Studies and Planning. This model has the twofold advantage of maintaining a light structure, thereby avoiding the setting up of a dedicated management unit, and structuring the intervention around the main functional linkages maintained with the technical and financial departments. However, the model was not apt in the specific organizational context, whether related to readability of the intervention or to management effectiveness and reasoning.

6. A large room for flexibility in the choice of areas of intervention and a relatively limited interface with the departments in charge of immunization led program promoters to fulfil the pressing needs whether or not tangibly related to immunization.

7. As a corollary, there was also a tendency to consider and use the program as a complement to the resources meant to respond to the unsatisfied needs and to support the activities planned earlier, whether these needs were related to immunization or not.

8. The intent to cover various levels of the health pyramid around five distinct areas of intervention created a dissipating effect. The division of resources was not good for the readability of the intervention and reduced its potential effect.

9. Persistent immunization bottlenecks were not sufficiently targeted by the intervention, particularly by the condition of community health workers, cold chain and transport logistics.

From institutional anchoring and the kind of GAVI-HSS steering

10. Unclear institutional anchoring was unfavourable to effective leadership and sufficient readability of the intervention. The absence of an unequivocal and recognized decision-making centre within the Ministry was felt during implementation and monitoring-evaluation of the intervention and this did not encourage effective management and real time responsiveness to difficulties in implementation.

11. Coordination mechanisms were not sufficiently formalized, before or during introduction of the intervention. Their performance also suffered from the absence of an unequivocal responsibility. Consequences were mainly felt on the implementation reliability in cases of complex activities (construction) and those concerning the central level.

12. The extremely limited presence of the Directorate of Prevention through Immunization in monitoring the program conveyed an image of dissociation among the health system strengthening activities and activities for improving vaccine coverage.

13. The human dimension proved essential in the observations made during GAVI-HSS implementation in Burkina Faso. In fact, the focal point was proof of great motivation even while this post was not formalized, and stakeholders at the peripheral level were efficient despite difficult working conditions.

From implementation

*Accuracy in implementation*

14. Accuracy in implementation at local level – region and district – is satisfactory: a large majority of activities conducted fall under the annual routine district program. Such integration led to a high degree of completeness and limited delay risks. The only shortfall in implementation at this level concerned the “search”/ “research” activities.

15. Activities that were delayed, not completed or not executed were mainly related to the central level. Two activity groups particularly lacked completion: (1) monitoring of intervention and (2) construction and equipment, which prove the most costly. Stakeholders involved in monitoring GAVI-HSS (DGSSS, HDSP, NHDP monitoring committee, HDSP steering committee, etc.) did not have an adequately coordinated reaction or even a suitable reaction to the extremely partial execution of construction activities during the implementation phase of the intervention.

16. Although they represent only a limited part of the number of activities carried out, building and equipping centres constitutes by far the most important expense item in intervention. It involves critical outcomes requiring a coordinated and farsighted management, adequate expertise in construction management, and meticulous monitoring. These conditions were not created.

17. For these activities, mechanisms of information, warning, communication, coordination and collaboration among different involved departments and programs of the MOH did not function effectively.

18. Annual reports clearly mentioned the difficulties in implementation. But reporting timelines were not favourable for quick and efficient decision-making. GAVI led various actions in the departments of the Ministry in response to the shortfall in implementation and poor resource utilization rates reported.

*Organization, management and monitoring of activities*

19. The informal mechanism helped ensure successful execution and acceptable monitoring of tasks at the peripheral level and activities requiring minimal management. But, this mechanism proved ineffective in managing more complex and costly activities.

20. Shortfalls in implementation largely stem from the absence of leadership by a management and coordination unit equipped with a formal mandate, responsible and accountable for implementing actions and managing interface with the peripheral level, central departments of the Ministry, steering committee and the partnership (GAVI Alliance).

21. To monitor the intervention, the central level gave priority to its existing monitoring system: HSPC monthly reports, HD and RDH quarterly reports, HDSP half-yearly progress reports, and sessions on funding and adopting district action plans.

22. With the current reporting system, stakeholders involved in decision-making (HDSP, DGSSS, GAVI) are informed of any progress in GAVI-HSS implementation with a time lag of several months, sometimes even a year, which is unfavourable for effective decision-making and avoiding loss of resources.

*Resource utilization*

23. Deadlines assigned to resource utilization in health districts were respected on the whole.

24. In reality, overall poor utilization rate observed is a result of the extremely low utilization rate in a small group of activities that are also the most costly.

25. Poor resource utilization rate in construction-related areas of intervention is due to inadequate management. The Ministry of Health has experienced staff in this subject and can be employed in this kind of activities.

*GAVI and other TFP participation*

26. GAVI's involvement in monitoring the progress of intervention was compliant to its mandate and its philosophy to provide support and assistance to the beneficiaries.

27. Five GAVI missions were carried out during the term of the intervention. The GAVI-HSS component appears to have been raised in most of the interactions among the national party and members of the missions. Several emails bear witness to GAVI Secretariat's concerns regarding implementation of activities and delays encountered in fund utilization.

28. The APR-based monitoring system provides a fairly enlightening annual summary on the activities' progress. Deadlines for preparing and sending these reports however do not help in quick decision-making in case of problems. More flexible and regular modes of communication would prove a better interface between the national party and the organization.

29. Partners participated in the formal process that gave GAVI-HSS monitoring and approval of annual reports its rhythm year after year. However, there are no factual details showing their concrete or active involvement in implementing activities related to areas of intervention, nor in supporting intervention management.

*Results*

30. Burkina Faso shows a secular rising trend in the number of immunized children. This trend takes countrywide progress into account. It is in all probability attributable to the entirety of mechanisms and actions led by the national authorities, actions that are neither identified nor made conspicuous in the purview of this investigation.

31. Activity progress in specimen districts, which have benefited from direct support from GAVI-HSS, is comparable to that in other districts.

32. We do not see any change in the trajectories (inclinations) observed in the specimen districts after implementing the intervention. In other words, we cannot bring out the presence of a measurable effect on immunization.

33. The indicators chosen by GAVI-HSS cannot account for the effectiveness of intervention. The infant and child mortality indicator is not appropriate in the given circumstances. Indicators added by the Ministry of Health are in accordance with the main objectives mentioned in the application, but they are less informative. None of them are related to the health of the child and they are insufficient in their specificity and sensitivity to change.

34. It is possible that an intense HSS strategy focused on immunization and actively implemented and executed over a longer period of time could show measurable results in short, medium and long-term vaccine coverage.

*A well-known situation*

35. A review of the evaluation reports commissioned by GAVI and related to HSS shows that in many ways, the situation encountered in Burkina Faso can be compared to that in other countries. Let us note for example:

    i. Inadequate attention paid to monitoring and evaluation of GAVI-HSS intervention;

    ii. Difference between reporting systems of HDSP (quarterly report) and GAVI (annual report);

iii. Gap between the year in which the funds were received and the time when implementation started;

iv. Late receipt of the first instalment of funds intended for implementing the intervention.

Related to some specific activities

36. Inadequate understanding of the complexity of some activities leads to failures in implementation as observed in all construction-equipment activities planned.

37. Intervention choices must be “feasible”. A reasonable risk-evaluation must be carried out. Maintenance is one such example.

38. The choice of some a priori relevant interventions such as mobilization and social marketing in areas with poor service utilization rate proved to be irrelevant because the contracting procedure which is a fundamental strategy for these interventions does not target immunization activities.

39. The DQS support opportunity by GAVI-HSS does not have a consensus; it must be explicitly reviewed.

**2. Recommendations**

Encourage a common GAVI-HSS vision

*For GAVI*

1. Clarify GAVI’s concept of “HSS-immunization” to national partners.

2. Eliminate any ambiguity in the nature of HSS intervention and position it clearly as an “intervention built on the enumerated action strategies” or as “a financial mechanism meant to fulfil the unsatisfied needs”.

3. Adapt forms and other documents provided to the Ministry of Health for preparing its application or for monitoring the implementation of the project, according to the preferred positioning.

4. Limit changes in forms to be filled by the national party.

*For GAVI and the Ministry of Health*

5. Promote the emergence of a common vision of what health system strengthening means in relation to immunization.

*For the Ministry of Health*

6. Follow the policy of aligning areas of intervention with national policies and anchor action plans for the peripheral level.

7. Create conditions required for promoting an understanding that is common to “HSS-immunization” and the stakeholders’ support.

8. Promote a participatory systematic approach at all design and implementation stages of the intervention involving the centre and the peripheral level.

9. Ensure a coherent, unequivocal and readable institutional positioning of the intervention encouraging recognition by all directorates and departments, an efficient leadership and management, coordination between different ministerial entities and an effective decision-making.

Review the planning approach (impact, participation of the peripheral level, dissociation program – vision)

*For GAVI and the Ministry of Health*

10. Substitute the current micro-planning by a more flexible and adaptive approach based on:
    i. A triennial planning focused on defining guidelines and global intervention strategies (strategic and tactical scope of planning);
    ii. An annual program based on a participatory approach fed by a process of continuous activity implementation monitoring on one hand, and mapping and prioritization of emerging needs on the other;
    iii. A more marked anchoring of the program in the health districts planning framework and guidelines (operational scope of planning).
11. Review expectations of the parties concerned with monitoring, keeping in mind the inherent opportunities and constraints of the health information system.
12. Select a battery of relevant performance indicators which are sensitive to change and adequately specific, rather than indicators for outcomes produced.

*For the Ministry of Health*

13. Create a process of needs analysis based on a systematic process of identifying current or anticipated bottlenecks, difficulties or shortfalls particularly related to immunization.
14. Follow a participatory approach in planning by involving peripheral stakeholders in the process of monitoring, mapping and prioritizing emerging needs, in a more tangible and structured manner.

*For GAVI*

15. Adapt planning forms to the flexible and adaptive approach suggested in the previous recommendations.

Ensure a tangible and more visible link with immunization activities

*For GAVI*

16. Inform bidders of the importance of tangibility of the link between HSS and immunization and include its evaluation in analysing the application.
17. Develop tools, situational simulations or illustrations to facilitate identification and selection of interventions falling within the logic of health system strengthening focused on promoting immunization. Support the development of local skills as per requirement.

*For GAVI and the Ministry of Health*

18. Make sure that the key constituents of the Ministry involved in organizing / providing immunization services (DGH, DPI, DGSSS and Directorate of Health Promotion (DHP)) contribute effectively and collectively to the process of needs identification, application preparation, and strategic-tactical and operational planning.

19. Conduct a collective exercise aimed at observing if there is a necessity (and in which case, how) to improve the current application (second phase of GAVI-HSS) for its improved anchoring in immunization activities and see that the needs intervention analysis is in sync with that of the concerned departments.

20. Appeal to national decision-makers and TFP to give more importance to maintaining the health system particularly the immunization system.

*For the Ministry of Health*

21. Target the HSS-immunization action levers in a better way with the help of an approach to identify the unmet needs.

22. Closely analyse logistics needs in immunization activities and anticipate future needs.

23. Strengthen anchoring and exploring of action strategies that will help use immunization as a stronger lever in the Ministry's community strategies.

24. Conduct a dialogue to clarify ministerial responsibilities and modalities in DQS implementation and funding and consequently decide whether GAVI-HSS should continue to support this activity.

Improve anchoring as well as monitoring and coordination capability of the Ministry of Health

*For the Ministry of Health*

25. Define and analyse different anchoring options possible for GAVI-HSS within the mechanisms of the Ministry of Health.

26. Review the roles and responsibilities of GAVI-HSS stakeholders (NHDP monitoring committee, HDSP steering committee, DGSSS, HDSP, DPI, DRH, DMT, TFP, etc.) to improve program readability and distinguish mandates specifically for each of the following key functions: (i) overall planning and management of interface with GAVI; (ii) monitoring activities at central, regional and provincial levels, including monitoring disruption of priority actions to be taken; (iii) delegation (if required) for the execution of certain activities in authorized structures.

27. Produce unequivocal responsibility matrices considering division of mandates and accountability of parties.

28. Make use of this review to further involve the Directorate of Prevention through Immunization (DPI) in steering and monitoring GAVI-HSS.

29. Set up a GAVI-HSS "Management Cell" or "Technical committee for monitoring" encompassing all expertise required for monitoring the implementation, coordination and steering of annual micro planning (mapping and prioritizing emerging needs, identifying bottlenecks and current or anticipated difficulties and/or shortfalls particularly related to immunization, periodic program reviews, interface with partners, and other mechanisms in the ministry and districts).

*For GAVI and the Ministry of Health*

30. For want of modifying the current reporting system, set up other mechanisms to improve dissemination of information about important aspects of implementation and to promote quick decision-making.

Strengthen and structure consultations between GAVI / other TFP and the Ministry of Health

*For GAVI*

31. Ensure harmonious links among different GAVI programs in Burkina Faso. Eventually plan for all of them to report to the same steering committee.

32. Promote a higher level of participation in implementation of activities, particularly the « risky » activities, exposed to possible shortfalls in implementation.

33. Develop reporting dynamics between GAVI and the GAVI-HSS National Coordination Team by building a relationship and a level of dialogue which helps the coordination team in better rolling out of HSS, preserving its spirit, and encouraging mutual understanding of the logic of intervention and respective constraints.

*For GAVI and the Ministry of Health*

34. Enrich the GAVI-HSS national coordination team with experiences of GAVI-HSS in similar countries.

## PREPARING THE GAVI-HSS2 APPLICATION

This section responds to GAVI's additional request to briefly check the extent to which some challenges faced during design and implementation of GAVI-HSS1 were considered. The analysis concerned the process of preparing the application submitted. It did not include an analysis of the contents per se of the program, which will call for a new intervention analysis.

1. The analysis is presented in the form of a structured table showing the main challenges identified during GAVI-HSS evaluation and aims to answer the following questions: (i) Was the application preparation process inclusive? (ii) Was the process of identifying bottlenecks transparent and systematic? (iii) Was GAVI-HSS better anchored with immunization activities? (iv) Is institutional anchoring of GAVI-HSS2 ensured and adequately readable? (v) Is the choice of program activities convincing? (vi) Were steps taken to bring about day-to-day improvement in management of activities? (vii) Was communication with GAVI Secretariat acceptable? The table is not reproduced in the summary.

2. It noteworthy that the evaluation team was pleasantly surprised by the quality of the GAVI-HSS2 application preparation. The level of preparation (readiness) of the Ministry for GAVI-HSS2 was adjudged superior to what it was for GAVI-HSS1. Several challenges identified during GAVI-HSS1 were spontaneously accounted for while preparing the application and discussions for approval.

3. Reviewing the proposal relied on the participatory process involving several exchanges back and forth among the stakeholders.

4. In terms of the encouragement given to the initiatives under analysis, we find: steps taken to ensure better institutional anchoring, refocusing of the application on immunization,

involvement of the Directorate of Prevention through Immunization, appointment of a monitoring and evaluation committee and a Coordinator, and reduction in construction activities.

5. The main weak point of the application is the excessively prescriptive and technocratic nature of the program. The team is convinced that a more flexible, adaptive and less prescriptive planning model will be required for a project whose basic essence is to respond to needs unmet due to circumstantial bottlenecks.

6. The alignment principle was also largely respected. GAVI's involvement in the preparation was as per expected norms. On the contrary, technical and financial partners did not appear very involved.

## CONCLUSION OF THE EVALUATION MANDATE

The mandate entrusted to the evaluation team was complete, facilitated by an effective and committed participation of the stakeholders. Beyond the positive evaluation formulated by the Ministry of Health regarding the participatory approach adopted throughout the evaluation, the national party emphasized value addition through lessons observed and recommendations made. The initiative taken by the monitoring and evaluation committee to invite the team to present the evaluation results to the Minister and his collaborators demonstrates how this evaluation translated the concern of the monitoring committee to ensure that the recommendations are indeed put into effect while implementing GAVI-HSS2.

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# LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| CHW | Community Healthcare Worker |
| IRC | Independent Review Committee |
| ECRH | Ethics Committee for Research in Health in Burkina Faso |
| CRCHUM | University of Montreal Hospital Research Centre |
| MEC | Monitoring and Evaluation Committee |
| HSPC | Health and social promotion centres |
| DPF | Directorate of Policy Formulation |
| DGSSSD | irectorate General of Studies and Sectorial Statistics |
| DGH | Directorate General of Health |
| DHP | Directorate of Health Promotion |
| DPI | Directorate of Prevention through Immunization |
| HD | Health District |
| DGH | Directorate General of Health |
| DMT | District Management Team |
| DHS | Demographic Health Survey |
| GAVI | GAVI Alliance |
| DCMO | District Chief Medical Officer |
| MOH | Ministry of Health |
| CBO | Community-Based Organizations |
| HDSP (Fr.) | Health Development Support Program |
| EPI | Expanded Program on Immunization |
| FP | Focal Point |
| NHDP | National Health Development Plan |
| NHP | National Health Policy |
| TFP | Technical and Financial Partners |
| PMTCT | Prevention of Mother-to-Child Transmission |
| CAPBD | Capacity-Building |
| APR | Annual Progress Report |
| HSS | Health System Strengthening |
| PHSRC (Fr.) | Public Health Study and Research Company |
| IEMD | Infrastructure, Equipment and Maintenance Department |
| NHIS | National Health Information System |

# LISTOF TABLES AND FIGURES

# SECTION 1 | MANDATE

In 2008, the GAVI Alliance (GAVI) responded favourably to Burkina Faso's funding request to support execution of health system strengthening (HSS) and immunization activities (2009/2011; US$ 4,978,773). The Central, Regional and District Directorates of Health (RDH, DDH) executed the activities covered by GAVI-HSS. At the end of 2012[2], several program activities were not yet complete. Although all the funds approved in 2008 were disbursed by GAVI, US$ 2,115,169 (42%) was not yet utilized by Burkina Faso. This situation prevails even while the second phase of GAVI-HSS (2013-2015; US$ 5,240,000) has already been approved and is soon going to be implemented.

In September 2013, GAVI and the Ministry of Health (MOH) financed an independent evaluation and entrusted it to the "Society for Public Health Study and Research (PHSRC, Burkina Faso) – University of Montreal Hospital Research Centre (CRCHUM, Canada)" consortium.

The evaluation covers the period 2008-2012 of GAVI-HSS funding and all activities carried out in 2013 using the same funds. The initial mandate concerns various intervention steps: preparing the application, submitting the GAVI application, implementing the activities, preparing and submitting annual reports, and results monitoring.

The initial terms of reference of the evaluation covered a large spectrum:

a) RELEVANCE

i. To what extent as the content of Burkina Faso's request for support submitted to GAVI:
   1. Relevant to the priorities of the country?
   2. Based on a rigorous evaluation of the main bottlenecks in the health system?
   3. Based on a clear change theory with solid links between the planned activities and improving the immunization program?
   4. Based on a solid monitoring and evaluation component?
   5. Aligned with GAVI's principles in terms of harmonization, predictability, orientation towards results and sustainability?

ii. To what extent was implementation aligned with the processes in force in the country particularly for health information systems?

b) IMPLEMENTATION

i. To what extent were the activities in HSS proposal implemented as planned (quality, quantity, modalities)?

ii. What were the important contextual and organizational factors that (positively or negatively) influenced the implementation of activities? Special attention must be paid to the role of:
   1. The new GAVI policy regarding funds disbursement.
   2. Centralized funds management by HDSP.

iii. To what extent did program management prove to be responsive to the difficulties faced?

iv. To what extent was rescheduling of activities relevant?

[2]Budget implementation statement 2013, is not yet available.

v. To what extent did GAVI Secretariat and local partners provide the commitment and support during the application process and the implementation phase appropriate and sensitive to contextual changes?

### c) Effectiveness/efficiency

i. To what extent did the subsidized program achieve the expected outcomes?
ii. To what extent can the results obtained (service coverage) be attributed to the GAVI-funded program?
iii. What measures could be taken to improve program efficiency?
iv. What are the contextual factors that could explain the level of achievement of the results?
v. To what extent were the financial resources used as planned and used in an efficient manner?
vi. What are the contextual factors that can explain the funds utilization rate for the funds received?

### d) Results/impact

i. To what extent did the HSS program influence:
    1. Child mortality rate for children less than 5 years of age?
    2. Penta3 vaccine coverage rate: the percentage of districts having achieved at least 80% Penta3 coverage (idem)?
    3. Other indicators selected by the country such as access to immunization services?
ii. To what extent does this type of support add value compared to other means of funding the health system?
iii. What were the (positive and negative) consequences of the HSS program?

### e) Perenniality

i. To what extent are the lessons learned from HSS program at different levels (national, regional and operational) perennial from the economic and program point of view?

### f) Lessons for the future

i. What are the important lessons that can be learned to help in better design and implementation of the HSS program in future, in Burkina Faso as well as other countries?

## 1.1 DEVELOPING A MANDATE

Given that the scope of initial questioning was incompatible with time constraints and available resources, GAVI consortium agreed to refocus the mandate. It was decided to lay more emphasis on the lessons to be learned from GAVI-HSS design and implementation and less on intervention resource utilization. It was also decided to defer the in-depth analysis of effects and impacts of HSS intervention and of sustainability of the program lessons.

Refocusing of the mission was agreed upon while providing "maximum protection" to the fundamental characteristics of evaluation design, quality of data collection procedures and precision in information processing. Using a Quality-Quantity mixed design and a combination of macro (national), meso (district), and micro (HSPC or community) components appeared unavoidable in order to answer the evaluation questions. In agreement with the study's sponsors, quantitative analyses were reduced to districts particularly targeted by the intervention, that is, the specimen districts. Deliberative processes were continued with key national level interlocutors, including technical and financial partners.

As specified in the reviewed and validated proposal:

- Questions regarding the adequacy of the intervention (relevance) as per GAVI principles in terms of harmonization, predictability, orientation towards results and sustainability (question i.5) and as per processes in force in the country, particularly in terms of health information systems (question ii) were not included;
- An analysis of effects and impacts was limited to: (i) longitudinal analysis of measurable changes in immunization activity in specimen districts; (ii) identification of eventually "good" results as a result of site visits, particularly those related to contextual factors which could explain the level to which results were achieved; (iii) identification of key national challenges that should be taken into consideration while deploying the next GAVI-HSS intervention team;
- An efficiency analysis is based rather on the process of qualitative investigation focused on delays in funds utilization;
- In the absence of an actual results analysis, the sustainability analysis is limited to identification of key national challenges concerning GAVI-HSS II.

## 1.2 INVESTIGATON METHODS – IMPLEMENTATION OF THE MANDATE

The evaluation team consists of four experts from the PHSRC-CRCHUM consortium. These institutions have fervently collaborated for the past 15 years in research, evaluation and knowledge transfer. Their works on the Burkinabe health system enjoyed great recognition and works regarding immunization figure among the reference texts cited by the GAVI application.

An understanding of the mandate, the theoretical framework used by the evaluation team, the methodological strategy and ethical questions are given in detail in the proposals of the evaluation team and in the protocol validated by the Ethics Committee for Research in Health (ECRH) in Burkina Faso.

Data was collected, processed and analysed between November 2013 and March 2014. The annexed technical report takes investigations and evaluation implementation steps into account.

The aide-memoire submitted in January 2014 gives details of the preparation, launch and collection stages of the evaluation.

The methodology stems from questions related to research, reference framework developed by the team, and the unique local context. It is presented in detail in the annexed report. The

investigation approach consists of three parallel processes: (1) a “macro” analysis of the program, its relevance, functioning, and lessons learned; (2) case-studies in 6 target districts; these case-studies being helpful in analysing processes, sustainability of effects, and in elaborating on the results; (3) integration of results of the analysis of program implementation in the districts analysed.

The evaluation design is mixed. Qualitative components predominate in answering evaluation questions related to relevance and implementation. Quantitative and qualitative components are required for consequences-related questions. Qualitative investigations call for interviews of key stakeholders, participants and beneficiaries, if required. Interactions are structured on the basis of interview guides. Interviews come with an analysis of the documentary and historical sources. The quantitative component relies on a longitudinal analysis of the national vaccine coverage database. All components of the evaluation include a participatory process which, as the case may be, covers all or part of the evaluation cycle: selection and prioritization of questioning and/or indicators and/or study area, contribution to finalization of methods, participation in selection of investigation sites (case studies) and data collection.

Case studies are a key component in analysing process and results. Keeping the intervention strategy in mind, the district was selected as the unit of analysis (one case = one district). Case selection process was carried out in several steps, in close cooperation with the MEC. The process accounted for the level of exposure of each of the 63 health districts of the country with the objective to give priority to districts with a fairly high level of exposure to the intervention so that it is translatable into visible achievements and thus districts whose results are measureable. Districts were selected by the MEC and the team based on an agreement according to which priority cases were districts: (i) having held activities covering several objectives of the intervention; (ii) where the density of exposure was adjudged average or high. Eventually, the six specimen districts selected were:

1. Dédougou (RDH of the Boucle du Mouhoun region)
2. Gayeri (Eastern RDH)
3. Karangasso-Vigué (RDH of the Hauts Bassins region)
4. Mangodara (RDH of the Cascades region)
5. Sapouy (RDH of the Centre-West region)
6. Solenzo (RDH of the Boucle du Mouhoun region)
7. Six specimen districts include the three districts proposed by the MOH evaluation FP in the name of MEC.

Regular field visits were carried out in the districts and aimed at: (i) collecting local information: interviewing stakeholders, gathering documentary sources, observing construction and equipment; (ii) identifying situations wherein a gap between the initial program and the actual activity was observed and encouraging stakeholders to talk about the reasons behind such situations, their sustainability, changes, etc.

Collecting regional level data completed investigations in the districts. Three Regional Directorates were included in the study:
1. Dédougou RDH
2. Hauts Bassins RDH
3. Cascades RDH

Sources used for the case study are the same as those used for the overall evaluation: documentary sources, field observations made by the survey team, interviews with participants.

Interviews conducted by the team total to 62:

- GAVI and central level Heads (n=16 on 18). Barring exceptions, they were one-on-one interviews. Some key Ministry of Health informers were met several times for a deeper

insight on the questions asked. Table 1 indicates the number of interviews planned and conducted with Heads from GAVI, Ministry of Health central level and Technical and Financial Partners (TFP) per category of stakeholders.

**Table 1: Planned and actual number of interviews with GAVI and the central level of the health system**

| | Planned | Completed |
|---|---|---|
| **GAVI HSS Burkina Faso** | 2 | 2 |
| **MOH-DGSS and ex-MOH-DSP** | 3 | 3 |
| **MOH-HDSP and ex-HDSP** | 4 | 4 |
| **MOH-DPI** | 4 | 4 |
| **MOH-DGSSS-DPF** | 2 | 2 |
| **TFP and consultants** | 3 | 1 |
| **Total** | **18** | **16** |

- Heads at the peripheral level: Forty-six interviews were conducted: (i) 18 with people at the regional level (Regional Director of Health, RDH team and representatives of capacity-building NGOs (CAPBD) as stakeholders in the MOH contracting policy; and (ii) 28 with people at the provincial level (District Chief Medical Officer (DCMO), District Management Team (DMT), Community Health Worker (CHW) and representatives of community-based organizations (CBO) as stakeholders in the MOH contracting policy.

A content saturation point was reached after conducting interviews in three regional directorates and five specimen districts out of the six planned districts. The team eventually gave up the idea of going to Gayeri, the sixth planned specimen district. However, it interviewed the District Chief Medical Officer who was in office from 2008 to 2013, the entire period covered by the HSS intervention. The evaluation team also interacted with two Heads of the District Management Team, Chief Medical Officer and Manager of two other districts not included in the list of specimen districts, to pose target questions. Table 2 gives the number of interviews conducted at the regional and provincial levels of the health system per category of stakeholders.

**Table 2 : Interviews conducted at the regional and provincial levels of the health system**

| | RDH 1 | RDH 2 | RDH 3 | HD 1 | HD 2 | HD 3 | HD 4 | HD 5 | Others |
|---|---|---|---|---|---|---|---|---|---|
| **RDH/DCMO** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 3 |
| **Administration** | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 |
| **EPI** | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | |
| **CISSE** | 1 | | | 1 | 1 | 1 | 1 | 2 | |
| **IEMD** | 1 | 1 | | | | | | | |
| **Monitoring-Evaluation** | | | | 1 | | | | | |
| **Pharmacist** | | | | | | | | | |
| **Other DMT** | 1 | | | | | | | | |
| **CHW** | | | | | 1 | | | | |
| **NGO CAPBD** | 1 | | | | / | | | | |
| **CBO** | / | | | 1 | | | | 1 | |
| **TFP** | | | | | 1 | | | | |
| **TOTAL** | **7** | **4** | **3** | **6** | **8** | **4** | **4** | **6** | **4** |

The list of people questioned is attached in Appendix 8 of the document.

Documentary sources were compiled throughout the entire study for the identified information required and the documents furnished by the stakeholders. These include – among others – project documents, reports and epistolary interactions from GAVI, various mechanisms of the Ministry, districts and health regions related to the intervention studied. The analysis specifically concerned annual progress reports submitted by the Ministry of Health to GAVI and commented upon by the MOH Independent Review Committee (IRC). A documents review related to construction activities archived under the Health Development Support Program (HDSP) was especially conducted in HDSP offices in December 2013. Some desired data and documents could not be collected, particularly the Financial Management Assessment report (FMA)[3].

Secondary data used include coverage statistics per month and per district, compiled within the National Health Information System (NHIS) framework. Some health districts and regions provided local data on coverage, dropouts, prenatal consultations (PNC) and assisted deliveries.

Data analysis put the reactions, opinions and information reported by the people into perspective. For all the components, stakeholders were involved in interpreting and validating the results. Due to a lack of consensus on the meaning of some of the results, our approach took into account factual details, team's conclusions, and existing potential differences in opinion on the interpretation and conclusions.

The main challenge of the team lay in processing the huge volume of data collected during the investigations. Changes in Heads and staff and absence of documentary sources were inopportune in precise retracing of some of the events studied. However, the diversity of respondents to the survey and the care taken to cover all stakeholders in the project helped undertake and illustrate different points of view and prevalent perceptions. Content saturation point was reached due to in-depth interviews of representatives at different levels that bolstered the confidence of the team regarding internal validity of the investigation approach.

The results integration approach was driven by an analysis of gaps in the initial program and actual achievements. These gaps were collectively discussed and interpreted by the stakeholders, particularly during a one-day workshop involving members of the MEC and the evaluation team. The approach successively included:

- A selection of about ten "critical" themes regarding activity groups whose accuracy in implementation was considered inadequate, or who faced specific difficulties in carrying out the intervention;
- A presentation of accuracy in implementation on the main task groups concerned with the intervention;
- A participatory interpretation of gaps, trying to understand the extent to which the gaps could be due to shortfalls in activity management and planning, functionality of decision flow and administrative flow and the prevailing situation and constraints.

[3]However, the team had access to the aide-memoire governing GAVI funds management for health system strengthening (HSS) and immunization services support (ISS) in Burkina Faso (December 2010) using the results of this FMA.

Compliant to arrangements with project overseers, the approach used to analyse efficiency is based on the qualitative process of investigation and not on the accounting analysis of allocations made.

An analysis of the consequences of intervention relies on an analysis of the value added by GAVI-HSS and the study of development in immunization activity for each of the antigens during the observation period 2006-2012. The 7 key informers surveyed, who were greatly involved in the intervention, provided an evaluation of the value addition attributed to GAVI-HSS by the national party.

### Participatory approach

In line with its commitment, the evaluation team adopted a participatory approach by involving stakeholders in evaluation at every step, particularly for interpreting and validating the preliminary results. They maintained contact with the MOH's monitoring and evaluation committee (MEC) through the designated focal point (FP) from the timework started and during a meeting with MEC's limited representation in December.

The first set of preliminary results was formally presented on December 23, 2013. The meeting also helped providing an outline of the terms of the participatory workshop planned for the following month.

A discussion workshop together with the MEC and the evaluation team was held on January 17, 2014 to: i) take stock of investigations and work progress; ii) present the principal lessons drawn from the preliminary analysis of GAVI-HSS activities; iii) make the participants give a serious thought to the means that would help ensure as favourable a GAVI-HSS implementation as possible. The terms of reference, introductory presentation and the eight forms used during the workshop are enclosed as Annex 9.

The participants' contribution to interpreting and validating the results helped put the observations in context and arrive at a common interpretation of the existing challenges and likely changes to reinforce GAVI-HSS funding and its effectiveness. Excellent support received from the participants in the proposed process and convergence of points of view regarding observations, lessons and provisional recommendations helped develop a diagnosis and common recommendations. The MEC and the evaluation team agree on recognizing the immense value added to the approach undertaken which promoted the appropriation of the evaluation results and above all of the recommendations that followed.

At the end of the workshop, on January 28, 2014, the team submitted an aide-memoire prior to the final report (Annex 10). At the end of the workshop, it summed up the main emerging themes for the study: i) an analysis of the data collected by the evaluation team and ii) sharing of its diagnosis and suggested recommendations with the MEC.

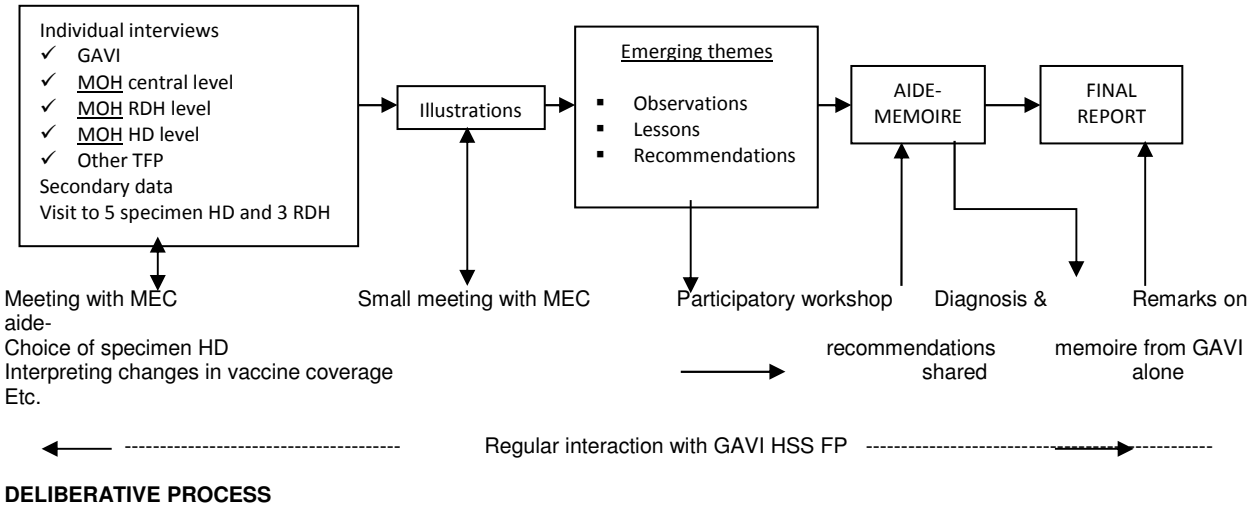
A feedback workshop for the provisional version of the final report was held on Tuesday, April 22, 2014, with the members of the MEC. With the exception of three members who had excused themselves, all other members of MEC participated in this meet chaired by the Director General of Studies and Sectorial Statistics, with participation of the GAVI Executive Secretariat representative. The meeting helped get feedback and suggestions from members of the MEC and GAVI representatives.

On MEC's suggestion during the meet, a presentation on conclusions and principal lessons

learned was made to the Council members of the Ministry of Health on May 9, 2014. The meet which essentially brought together the Directors General and technical advisers of the Ministry of Health was chaired by the Secretary General of the Ministry of Health in the absence of the Health Minister.

Figure 1 sums up the process followed by the evaluation team.

**Figure 1: Summary of the process followed by the evaluation team**



# SECTION 2 | CONTEXT

Burkina Faso spreads over an area of 274,200 km². The last census estimated the total population at 14 million and growth pace at 3.1% (GCPH 2006). Women represent 51.7% of the total population. Burkina Faso falls in the list of low-income countries. Its Human Development Index (HDI) was 0.343[4] in 2012, making it 183rd out of 186 countries. The level of education continues to be poor: 69.8% of the 6-year olds have not received any education. Overall, 70% of the women are uneducated[5]. There are distinguishable gender-specific inequalities in this field; literacy rate is 23% in women and 38% in men.

General mortality rates are relatively high although they tend to be declining. Between 2003 and 2010, the probability of dying between 15 and 50 years has gone from 158‰ to 146‰ in women and from 200‰ to 145‰ in men[6]. Maternal mortality is estimated at 341 deaths in 100,000 live births. Child and infant mortality has declined (177‰ in 1998/99 vs. 129‰ in 2010); however, it remains extremely high and reveals significant regional disparities. Nutritional condition of children is still a cause for concern. Acute malnutrition prevails at 8.2%, chronic malnutrition at 31.5% and more than one in five children are underweight (21%)[7,8].

The national health system is organized in a pyramid-like structure based on the classical three-level model: (i) the central level defines policy and ensures technical and administrative coordination among health services, (ii) the intermediate level comprises 13 Regional Directorates of Health (RDH) that implement the Government's health policies in the regional health space and (iii) finally, the peripheral level comprises 70 health districts including 63 considered functional in 2012. The following map (figure 2) shows the contours of the districts and highlights the specimen districts of our GAVI-HSS evaluation.

The healthcare mechanism encompasses several types of establishments with its foundation of a network of health and social promotion centres (HSPC), dispensaries and isolated maternity hospitals. These health centres provide primary healthcare and refer patients to the Medical Centres with Surgical Units (CMA) or to hospitals. Nine out of 13 health regions have a regional hospital (RH). Three hospitals enjoy academic status.

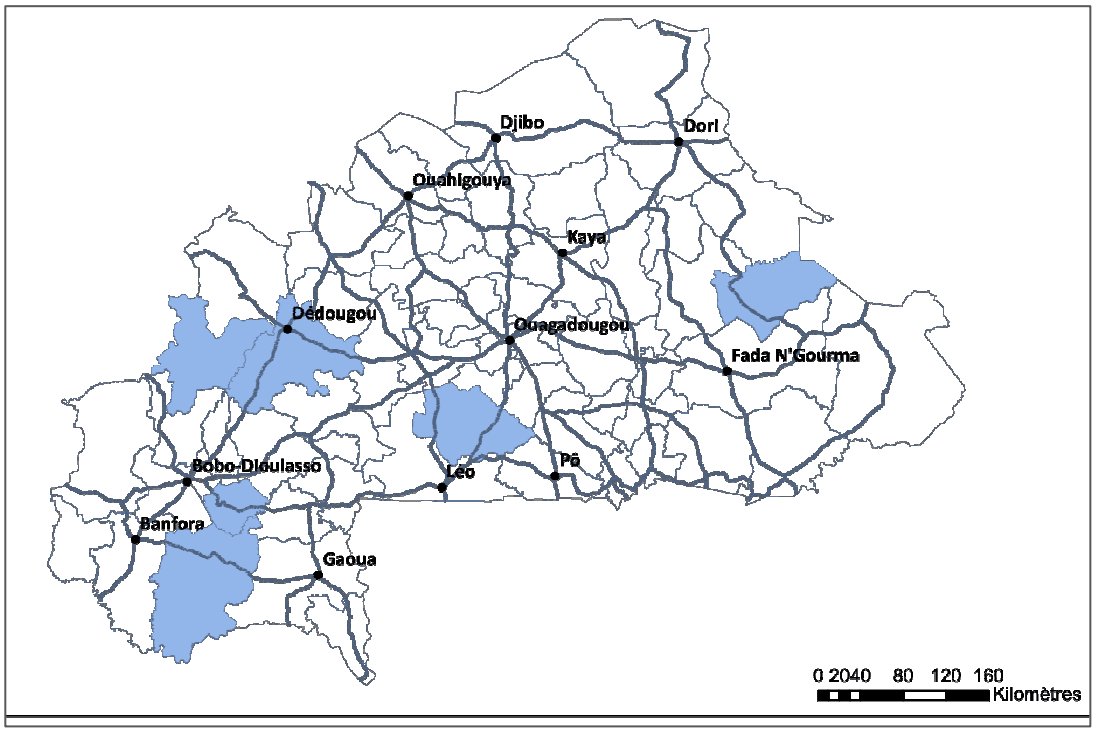
Since 2001, the country committed itself to strengthening the sectorial approach in health by equipping itself with strategic instruments, the National Health Policy (NHP), the National Health Development Plan (NHDP), and financial instruments like sectorial budgetary support, and health development support program (HDSP). Implementing the National Health Policy helped, on one hand, in strengthening healthcare supply through gradual reduction in the average radius for access to Basic Health Centres, and on the other, in innovating, in terms of stimulating healthcare demand, by subsidizing deliveries and emergency obstetric and neonatal care (EONC), providing free preventive and promotional healthcare[9] for children and mothers, developing a contractual approach, etc. among other things.

[4] Human Development Report 2013
[5] DHS-MICS IV Report 2010
[6] Demographic and Health Survey 2003 and 2010
[7] National Nutrition Survey on the prevalence of malnutrition, 2013
[8] MOH, Directorate of Nutrition: National Nutrition Survey on the prevalence of malnutrition; October 2013

[9] Prenatal consultation, immunization, post-natal consultation, consultation for healthy infants

According to progress reports by the Ministry of Health, the average radius (Km) for action by Basic Health Centres reduced from 9.18 to 7.1 in 2012. Furthermore, the proportion of HSPC meeting staffing standards rose from 73% in 2001 to 85.3% in 2012. There is a general increase in the rate of caesareans: from 1.8% in 2011 to 1.9% in 2012[10]. The rate of assisted deliveries also soared from 31% in 2003 to 82% in 2012.

**Figure 2: Map of Health Districts in Burkina Faso with the assessed 6 specimen districts**




National health expenditure is assessed at 338.85 billion CFA Francs (F CFA) in 2012 against 305.78 billion CFA Francs in 2011[10]. We observe a 10.82% rise between 2011 and 2012. In terms of per capita national health expenditure, the national health accounts (NHA) results show an irregular rise in the past five years. Between 2011 and 2012, it increased by 7.3%, rising respectively from 18,819 to 20,195 CFA Francs[11].

Developing the sectorial approach in health is however confronted with difficulties, particularly:

i. Inadequate development in sectorial dialogue between the Government and technical and financial partners. Functioning of the monitoring committee and the NHDP technical implementation commissions is also inadequate;

ii. Absence of real project and program coordination, and of a management unit for them;

iii. Inadequate coordination in the private sub-sector[12].

Mobility of stakeholders from different levels is important. Therefore, between 2009 and 2013, three Health Ministers and three Secretary Generals of the Ministry succeeded one another. These changes usually come along with organizational changes (consecutive reviews of the

[10] National Health Accounts, 2011-2012
[11] Ministry of Health: Health accounts, 2011 and 2012, December 2013
[12] NHDP 2011-2010, p7

MOH organizational chart), which are also an opportunity to make important moves in the staff. But, this is unfavourable for preserving institutional memory, continuing the management of strategic options and permanent partnerships. During one such review of the Ministry of Health organization chart, the Directorate of Studies and Planning (DSP) became the Directorate General of Studies and Sectorial Statistics (DGSSS).

In addition, the Health development support program (HDSP) initially designed to mobilize non-target-based funds for implementing district action plans experienced an opposite situation. Funds mobilized through this common basket initiative became more and more target-based (53% in 2012)[13]. In terms of its overall performance in funds management procedures for MOH structures, this program continues to be a preferred channel for the Ministry to mobilize and manage its financial resources.

Immunization activities at central level fall under the Directorate of Prevention through Immunization (DPI) within the Directorate General of Health. Immunization efforts have led to a continuous improvement in full vaccine coverage (74% in 2010[14]), new vaccines have been introduced and we see a reduction in epidemics, particularly measles.

Immunization activities in health districts are conducted by health and social promotion centres (HSPC) based on a classical model combining fixed and advanced strategies and social mobilization actions. Everything is reinforced by special immunization campaigns, additional activities (Vitamin A and Iron supplements, deworming and distribution of insecticide-treated mosquito nets) and integrated surveillance of potentially epidemic diseases.

The immunization program enjoys the support of various partners. Global Alliance for Vaccines and Immunization (GAVI) intervenes through strengthening of immunization services and vaccine safety and since 2009, through the Health System Strengthening (HSS) program. But, challenges are many and GAVI HSS's intervention is driven by persistent challenges that include[15] maintaining and improving vaccine coverage.

To be more specific, GAVI intervention targets the following: correcting inadequacies in organizing and managing healthcare services, human resource development in the health sector, social mobilization, coverage in primary healthcare centres, and maintenance system for equipment and infrastructure.

[13] MOH-HDSP: Evaluation of the 2008-2012 phase, February 2014
[14] DHS-MICS IV, 2010
[15] GAVI Alliance/Government of Burkina Faso (2007). Burkina Faso proposal for GAVI support to Health System Strengthening (GAVI-HSS) – September 2007.

# SECTION 3 | GAVI HSS INTERVENTION IN BURKINA FASO

This section outlines: i) the process followed in preparing the GAVI-HSS application and ii) the continuing intervention strategy in the country.

## 3.1 PREPARATION AND APPROVAL PROCESS FOR GAVI HSS APPLICATION

Table 3 sums up the main steps in preparing the GAVI-HSS proposal and getting it validated by the GAVI Alliance[16].

**Table 3: Main steps in the preparation and validation process of GAVI-HSS proposal**

| | |
|---|---|
| **2006** | – Decision of the Directorate of Studies and Planning (DSP, current DGSSS) to prepare an application requesting for GAVI Alliance fundi strengthening its health system.<br>– Appointing a DSP executive team to carry out the application preparation process.<br>– Setting up a small drafting team comprising technicians from DSP, Directorate of Prevention through Immunization (DPI), Directorate Ge of Infrastructure, Equipment and Maintenance (DGIEM) and health development support program (HDSP), supported by the national consultant. |
| **2007** | - Analysing and validating the proposal prepared by the Monitoring Committee of the National Health Development Plan (NHDP-MC) in Feb 2007 and GAVI Alliance application program in May 2007.<br>- Changing guidelines for GAVI support to HSS and formulating an accompanying proposal in March 2007 (publication of revised 2007 ve and conducting a regional technical workshop organized in Ouagadougou).<br>- Decision of MOH to set up a small drafting committee to draft a new proposal accounting for the changes made in guidelines for GAVI su to HSS.<br>- Work sessions and then workshop to prepare the application from June 4 to 7, 2007 with participation from the national consultant, Health Organization (WHO) and United Nations Children's Fund (UNICEF).<br>- Revision by the Ministry's directorates, Technical and Financial Partners, NHDP Technical Secretary (NHDP-TS) and HDSP coordinator.<br>- Consensus workshop involving the commission 'Sectorial approach to NHDP', Regional Directors of Health (RDH) and District Chief M Officers (DCMO).<br>- Analysis and validation of the new GAVI-HSS proposal by the NHDP-MC on September 21, 2007.<br>- Signatures of the Minister of Health and Minster of Economics and Finance (October 2, 2007) and submission of application to GAVI Allian |
| **2008** | - Burkina Faso's response to GAVI Alliance regarding conditions related to its proposal for health system strengthening, March 7, 2008.<br>- GAVI Alliance approval "subject to clarifications", May 10, 2008.<br>- Approval of Burkina Faso's proposal for health system strengthening for a total amount of US$ 4,978,500 after clarifications made on the request of the Independent Review Committee (IRC) of GAVI-HSS, August 14, 2008. |

The process, coordinated and supervised by the Directorate of Studies and Planning (DSP, currently DGSSS) of the Ministry of Health (MOH), lasted two years (2006 to 2008).

[16] Sources: documentary review, interviews, Burkina Faso proposal document for GAVI support to Health System Strengthening September 2007 – (GAVI-HSS).

Involvement of the Ministries and TFP is not limited to the Ministry of Health and the three main multilateral agencies (WHO, UNICEF and WB) mentioned in table 1. The NHDP monitoring committee which played the role of Health Sector Coordination Committee (HSCC) demanded by GAVI Alliance for examining and approving the proposal, comprised officers from the Ministry of Health, Ministry of Economics and Finance, Ministry for Territorial Administration and Decentralization, Ministry for Civil Service and State Reform, as well as other technical and financial partners (Embassy of Netherlands, WHO, UNICEF, etc.) including Civil Society Organizations (CSO) and the private sector in the health industry.

The GAVI Alliance Board of Directors approved the proposal following the recommendation of the HSS support Independent Review Committee (IRC).

## 3.2 GAVI HSS INTERVENTION STRATEGY

**The intervention is structured around 5 areas of intervention:**

1) Improve organization and management of health services;

2) Develop human resources in the health industry;

3) Strengthen community mobilization and social marketing in areas with poor health service utilization rate;

4) Improve system infrastructure, equipment and maintenance;

5) Reinforce basic infrastructure and equipment in the least served areas.

These areas of intervention are divided into 44 main activities or group activities. The list of activities is given in table 4. For each activity, the table shows budgeted financial resources (in value and percentage of the total budget), some indications about their scope (activity conducted at the peripheral or central level), their degree of specificity (activities specific to immunization or generic activities whose consequences can be linked to several programs) and potential in terms of health system strengthening (activities in response to immediate service needs or those which can have an effect on the system in the medium and/or long term).

The initial duration of GAVI-HSS was three years, from 2008 to 2010, so as to simultaneously end the NHDP 2001-2010. Funding allocated in 2008 to GAVI-HSS was US$ 4,978,500. DSP was responsible for implementing GAVI-HSS, HDSP for its financial management, and the NHD Monitoring Committee for its coordination, monitoring and control in the capacity of Health Sector Coordination Committee (HSCC).

**Table 4: GAVI-HSS activities per area of intervention, with budget, intervention level, degree of specificity in terms of immunization and potential in health system strengthening**

| Activity per intervention area | | Budget (USD) | Budget (%) | Intervention Level | Specification / | HSS Potential |
|---|---|---|---|---|---|---|
| **1** | **Improve organization and management of health services by 2010** | **1,619,738** | **33%** | | | |
| 1.1 | Conduct an annual survey of EPI data validation in HD | 56,254 | 1% | District | Specific | Poor |
| 1.2 | Give financial support to districts to implement strategy to search for the immunization dropouts for preventive and curative activities (63 HD) | 168,595 | 3% | District | Specific & Generic | Poor |
| 1.3 | Conduct external evaluations of implementation of GAVI activities in districts | 67,382 | 1% | District | Generic | High |
| 1.4 | In each semester, conduct quality control of routine data in health centres | 46,380 | 1% | Health Facility | Generic | Poor |
| 1.5 | Review health data collection material and mechanisms of the health information system | 137,000 | 3% | Central | Generic | High |
| 1.6 | Give financial support to 10 HD with poor financial resources, for integrated monitoring of MAP activities in HSPC | 33,719 | 1% | District | Generic | Poor |
| 1.7 | Support the health information system in collection, analysis and distribution of statistical data | 77,273 | 2% | Central | Generic | Poor |
| 1.8 | Set up a pilot model for local maternal and child health services within the communities in 3 villages of 3 districts over 3 years (HD of Zabré, Léo and Pô) | 54,748 | 1% | Community | Generic | Poor |
| 1.9 | Support the creation of 8 obstetric emergency management cells within the communities in Zabré, Léo and Pô districts | 186,182 | 4% | Community | Generic | Poor |
| 1.10 | Conduct operational research on reference and counter reference in two pilot districts (Orodara and Fada Ngourma) | 4,909 | 0% | District | Generic | High |
| 1.11 | Support the setting up of health insurance in HD with poor health service utilization (Sapouy, Djibo, Dori, Dédougou) | 18,182 | 0% | District | Generic | Poor |
| 1.12 | Conduct operational research on epidemiological surveillance in 5 distinct HC and 5 distinct HD (Ouargaye, Pô, Banfora, Dano and Batié) | 18,182 | 0% | Health Facility | Specific and Generic | High |
| 1.13 | Hold 2 GAVI-HSS activities implementation evaluation meets every year at the regional level | 292,242 | 6% | Region | Generic | Poor |
| 1.14 | Hold 1 GAVI-HSS activities implementation evaluation meet every year at the national level | 93,290 | 2% | Central | Generic | Poor |
| 1.15 | Equip 5 newly created HD with initial grant of Generic Essential Medicines (Pouytenga, Bittou, Léna, Baskuy and Karangasso Vigué) | 365,400 | 7% | District | Generic | Poor |
| **2** | **Develop human resources in the health industry by 2010** | **501,662** | **10%** | | | |
| 2.1 | Implement the community health workers' skill reinforcement plan (EPI, community ISCI, FP and recognizing danger signs related to pregnancy) | 112,396 | 2% | Community | Specific & Generic | High |

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| 2.2 | Reward the two best HS per district on the basis of annual results, particularly in vaccine coverage | 70,810 | 1% | Health Facility | Specific | High |
| 2.3 | Train stakeholders at the HSPC level in health planning for better consideration of preventive and curative activities | 236,364 | 5% | Health Facility | Generic | High |
| 2.4 | Make an orientation plan for school teachers and trainers in training institutes for health staff based on the EPI and RH programs management model | 18,182 | 0% | Central | Specific | High |
| 2.5 | Hold a workshop for reviewing training curricula used in schools and training institutes for health staff based on EPI and RH programs management | 18,455 | 0% | Central | Specific | High |
| 2.6 | Support the execution of research activities in EPI in 5 HD with poor EPI indicators (Séguénéga, Kombissiri, Sapouy, Nongremassom, Dandé and Gayérie) | 45,455 | 1% | District | Specific | High |
| **3** | **Strengthen community mobilization and social marketing in areas with poor health service utilization rate** | **196,568** | **4%** | | | |
| 3.1 | Contractualize social mobilization and social marketing in the health industry with the private sector in 2 HD (Sapouy and Dédougou) | 77,509 | 2% | District | Generic | Poor |
| 3.2 | Conduct an annual external evaluation of performance of contracting organizations for social mobilization in 2 HD (Sapouy and Dédougou) | 51,673 | 1% | District | Generic | High |
| 3.3 | Conduct operational research on community-based epidemiological surveillance (SEBAC) for EPI target diseases in 6 HD with poor EPI indicators (Séguénéga, Kombissiri, Sapouy, Nongremassom, Dandé and Gayéri) | 13,636 | 0% | District | Specific | High |
| 3.4 | Train and mentor CHW involved in implementing health programs in all HD | 53,750 | 1% | Community | Generic | High |
| **4** | **Improve infrastructure, equipment and maintenance of the system** | **552,879** | **11%** | | | |
| 4.1 | Train 300 users in regular up-keep of medico-technical equipment | 56,198 | 1% | Health Facility | Generic | High |
| 4.2 | Train 30 cold chain maintenance technicians | 5,536 | 0% | District | Generic | High |
| 4.3 | Equip DGIEM with a 4x4 maintenance vehicle for biomedical equipment including cold chain equipment | 27,273 | 1% | Central | Generic | High |
| 4.4 | Outsource corrective maintenance of biomedical equipment to the private sector | 280,963 | 6% | Central | Generic | High |
| 4.5 | Build and equip 1 IEMD in 1 health region (Cascades) | 72,727 | 1% | Region | Generic | High |
| 4.6 | Build and equip 3 maintenance workshops in 3 health districts (Léo, Indou, Diapaga) | 66,109 | 1% | District | Generic | High |
| 4.7 | Build 3 good functionality and high capacity incinerators in 3 health regions (Centre West, South-West and Central East) | 44,073 | 1% | Region | Generic | High |
| **5** | **Reinforce basic infrastructure and equipment in the least served areas by the end of 2010** | **1,604,520** | **32%** | | | |
| 5.1 | Build and equip 5 HSPC in areas with poor health coverage: Sami (HD of Solenzo), Varpuo (HD of Dano), Sassamba (HD of Mangodara), Boulmatchiangou (HD Diapaga), Datambi (HD of Sebba) | 667,000 | 13% | Health Facility | Generic | High |
| 5.2 | Equip 4 health districts with 4 of 4x4 pick-up vehicles for supervision (Lena, Gayerie, Karangasso Vigué, Sebba) | 218,182 | 4% | District | Generic | High |
| 5.3 | Equip 100 HSPC with motorcycles for advanced strategy activities (HSPC) | 236,364 | 5% | Health Facility | Generic | High |

| | | | | | | |
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| 5.4 | Equip the DSP's Health Information Department with a 4x4 vehicle to strengthen NHIS in monitoring the quality of statistical data | 54,545 | 1% | Central | Generic | High |
| 5.5 | Equip village cells of 4 health regions (Centre Est, Boucle du Mouhoun, Centre West and Centre North) with 400 bicycles for implementing community-level activities in immunization, distribution of contraceptives, micronutrients and community-based surveillance | 58,182 | 1% | Community | Generic | High |
| 5.6 | Equip DPI with a 15-ton truck for supplying regional depots with vaccines, medicines, medical consumables and other material | 109,091 | 2% | Central | Specific | High |
| 5.7 | Equip 3 CMA with ambulances for referrals and medical evacuations | 212,727 | 4% | District | Generic | High |
| 5.8 | Build and equip 2 EPI depots in 2 of the 8 newly created HD (Mani, Mongodara) | 48,429 | 1% | District | Specific | High |
| | **Support costs** | **4,475,367** | **90%** | | | |
| | **Management cost (7% of support cost)** | **348,514** | 7% | | | |
| | **Support cost for M & E** | **124,469** | 3% | | | |
| | Make regular field visits for monitoring implementation of GAVI-HSS | | | | | |
| | Support the functioning of ST NHDP/DEP- for monitoring the implementation of GAVI HSS | | | | | |
| | Conduct mid-term evaluation of GAVI-HSS implementation | | | | | |
| | Conduct a final evaluation of GAVI-HSS implementation | | | | | |
| | **Technical assistance** | **30,426** | 1% | | | |
| | **GENERAL TOTAL** | **4,978,776** | **100%** | | | |

# SECTION 4 | RELAVENCE ANALYSIS

The evaluation questions for the relevance analysis put forth by the reviewing team are as follows:

i) To which extent was the content of Burkina Faso's support request to GAVI:

(1) Relevant with regard to the priorities of the country;

(2) Based on a thorough analysis of the main bottlenecks affecting the health system;

(3) Based on a clear theory of change with strong linkages between planned activities and the improvement in the immunization program;

(4) Based on a strong monitoring and evaluation component.

We reiterate that for issues concerning the compatibility of the request with GAVI's principles on standardization, predictability, results and sustainability orientation (question i.5) and with the processes in force in the country, particularly the health information system (question ii), the original terms of reference for this evaluation were removed from the mandate.

## 4.1 TO WHAT EXTENT WAS THE CONTENT OF BURKINA FASO'S SUPPORT REQUEST TO GAVI RELEVANT WITH RESPECT TO THE PRIORITIES OF THE COUNTRY?

### 4.1.1 GAVI HSS proposal drafting process entirely managed by the national party

As described in the previous section, the GAVI HSS proposal drafting process was driven entirely by the Directorate of Studies and Planning (DSP, current Division for Economics and Sectorial Statistics -DGSSS) of the Ministry of Health (MH). It was the result of a genuine planning effort made by the MH that took the necessary time and engaged the services of a national consultant, a former senior health official of Burkina Faso. The Department of Prevention by Vaccinations (DPI) and the Health Development Support Project (HDSP) were closely associated, though to a lesser extent, than the other departments and programs (DGIEM, etc.), the regions and the health districts of the MH and the main technical and financial partners (the Dutch Embassy, WHO, UNICEF, etc.). The participation of the Ministries of Economy and Finance, Territorial Administration and Decentralization, Civil Service & State Reform, of civil society organizations (CSO) and the private health sector was concretized through the NHDP monitoring committee.

Nonetheless, the peripheral groups, although inclusive in nature, perceived the approach as being "top-down".

### 4.1.2 Strategic planning within the framework of the National Health Policy

The GAVI HSS strategy was defined by taking into consideration needs and in line with the strategic guidelines of the National Health Policy (NHP), National Health Development Plan (NHDP) 2001/2010 and several documents and national policy guidelines (mid-term review and the ex-ante evaluation (period 2006/2010) of the NHDP, annual planning guidelines of the DSP, action plans of the Health Districts (HD), analysis of the systemic determinants of the

immunization coverage in the HDs of Burkina Faso[1817], etc.). As a reminder, the importance of immunization as a fundamental strategy to control the Vaccine-Preventable Diseases is retained as a key factor in the NHDP to reduce infant mortality, which continues to be extremely high in Burkina Faso. In view of this, the NHDP lays emphasis on the enhancement of the delivery of quality health services for the mother and the child as well as on the intensification of community-based services.
The duration chosen for GAVI HSS in 2007 was 3 years to align it with the schedule of the on-going NHDP.

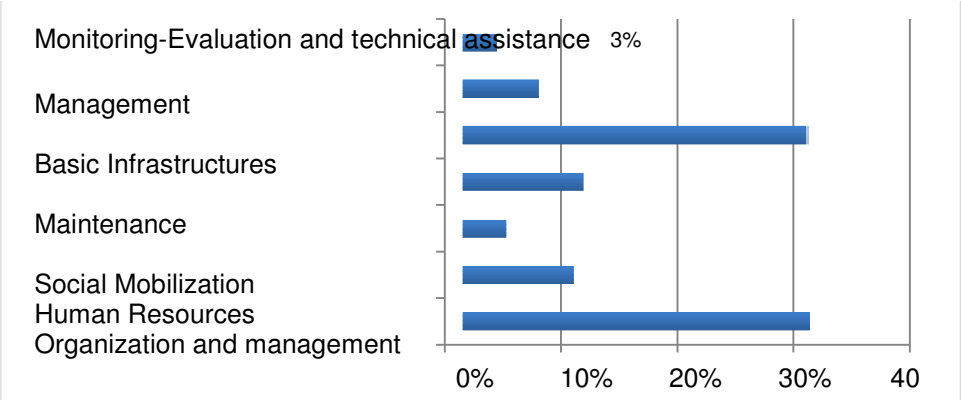
### 4.1.3 Intervention areas and prioritized activities

The intervention is consistent with health system strengthening activities undertaken by GAVI. The aim consists in improving and maintaining high nation-wide immunization coverage by enhancing the capability of the health system to provide vaccination and other healthcare services, especially for the mother and the child.

The program choices, consistent with the National Health Policy of the country (NHDP 2001-2010) and flexibility in the creation and rolling-out of the intervention, are both necessarily dependent on this integration.

The resources allocated to the different intervention programs are extremely variable (figure 3). Two areas – Improvement in the organization and management of health services and up scaling of basic infrastructure and equipment in the least served areas – would consume two-thirds of the budget. The other heads – Improvement in the maintenance, equipment and infrastructure system and the health manpower development – would take up 11 and 10% of the total budget respectively and the area-based intensification of community mobilization and social marketing in regions with dismal health services utilization rates –would represent a share of 4%. About 3% of the budget is allocated to monitoring /evaluation and technical assistance.

**Figure 3 : Distribution of resources allocated to GAVI HSS per intervention area**




[178] Haddad S, Bicaba A, Feletto M, et al. System-level determinants of immunization coverage disparities among health districts in Burkina Faso: a multiple case study. BMC International Health and Human Rights. 2009; 9 (Suppl. 1):S15.

Activities benefiting from a greater share of allocations and hence subject to a more careful management are the following:

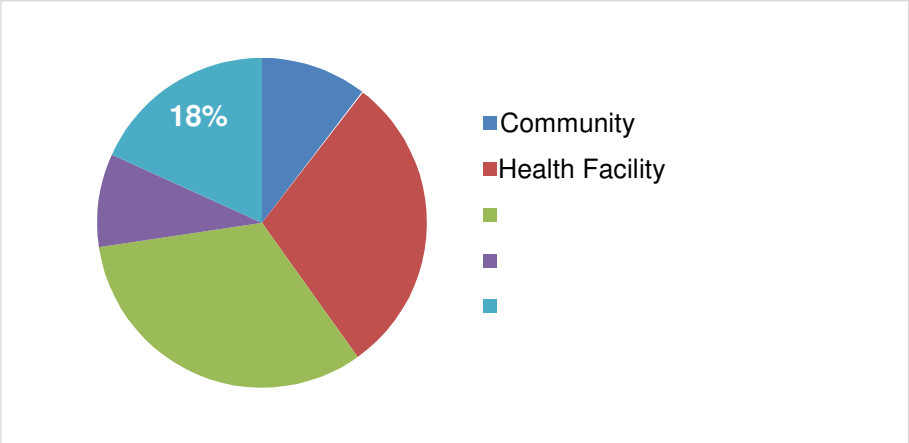
- (5.1) construction and equipping of 5 CHSP in areas of low health coverage;
- (1.15) providing 5 newly created health districts with initial supply of generic essential drugs;
- (1.13) holding 2 evaluation meetings each year at the regional level with regard to the implementation of GAVI HSS activities;
- (4.4) subcontracting the corrective maintenance of biomedical equipment with private sector parties.

The portion of these activities in the budgetary allocation is around 13, 7, 6 and 6% respectively. Other activities consume between 0 to 5% of the budgetary resources respectively.

#### 4.1.4 Prioritized levels and areas of intervention

The total share of resources allocated to community health (10%), health facilities (30%), districts (32%) and regions (9%) accounts for 82% of the budget of support costs and the percentage of resources envisaged for the central level is only 18% (figure 4). GAVI's willingness to mainly focus its health system strengthening initiative on the delivery of services at peripheral level is thereby complied with.

**Figure 4 : Distribution of resources per level of intervention**



Captions:

| | | | |
|---|---|---|---|
| Conmmunataire | : | Community | : 10% |
| Formation Sanitaire | : | Health facility | : 30% |
| District | : | District | : 32% |
| Regions | : | Regional | : 9% |
| Central | : | Central | : 18% |

From a geographical standpoint, 35% of the budget is allocated to activities specifically targeting 27 out of roughly 50 districts in Burkina Faso in 2007. In this 35% share, 13% is spent by construction activities of five CHSP (5 HDs), 7% by supply of drugs to the five new HDs and 4% through provision of 4x4 pick-up vehicles for supervision (4 HDs). This share of 24% of the total budget representing targeted effort from a geographical perspective benefits a total of 12 districts. The majority of these HDs are in areas where the health coverage is low.

In summary, the Ministry of Health led the entire proposal drafting process of GAVI HSS by keeping it in line with the national health policy framework. The majority of the strategic and operational choices made are relevant with regard to the priorities of the country:

 prioritization of interventions such as “Improvement in the organization and management of health services”, “Up scaling of basic infrastructure and equipment in the least served areas” and “Improvement in the maintenance, equipment and infrastructure system “in accordance with the mid-term review of NHDP, annual planning guidelines, etc.
prioritization of peripheral level;
Prioritization of districts where the health coverage is really low.

## 4.2 TO WHAT EXTENT WAS THE CONTENT OF THE SUPPORT REQUEST MADE BY BURKINA FASO TO GAVI BASED ON A THOROUGH ANALYSIS OF THE MAIN BOTTLENECKS AFFECTING THE HEALTH SYSTEM?

The four sets of obstacles to the improvement of the immunization coverage identified from the drafting processes described in the previous section are:
i) Inadequacies in the organization and management of health services;
ii) Feeble health manpower development;
iii) Lack of social mobilization for health initiatives;
iv) Insufficient national coverage of basic health infrastructure (CHSP) and maintenance system[2118].

Considering the ground realities of the country, the state of its health system and usable documentary sources at the time of planning, the evaluation team found these observations consistent.

### 4.2.1 GAVI HSS, mainly a health system strengthening initiative

Two-thirds (65%) of the budget is allocated to activities susceptible to have mid or long term impact
(HIS, training curricula, skill enhancement, research, construction, equipment, etc.) and that can hence be labelled “health system strengthening (HSS)”. Only one-third of the budget is used

[18]Ibid. p. 19, 20 and 21.

towards fulfilling the immediate needs (financial support, health supplies, meetings, supervisions, etc.). GAVI HSS centres on "HSS" as provided for in the strategy and goals of the concerned GAVI Alliance support funds.

#### 4.2.2 Partly imperfect addressing of priority needs for the implementation of immunization activities

It is useful to know that according to GAVI, the major barriers to the demand and supply of frontline and immunization services in the countries eligible for the health system strengthening support program concern primarily:

i) Mobilization, distribution and motivation of human resources;

ii) Organization and management of services at the district and more remote levels (frontline);

iii) Supply, distribution and maintenance systems.

Awarding benefits to health centres, updating portions of training curricula and conducting training activities can be perceived as a contribution to the development of human resources. Subsidizing transportation, assistance in day-to-day activities and the construction of health centres all contribute in their own way towards improvement in the district organization and management. However, in the absence of a systematic consultation and needs analysis process for the concerned districts, it is difficult to comment, even after almost 8 years, on the relevance of these choices and their scope in terms of capacity-building of human resources or of health districts.

*However, there is evidence to suggest that there are critical issues well beyond the districts covered and it is perhaps a matter of some regret that GAVI HSS did not take stock of these needs and the bottlenecks that these could present.*

*The resilience of the vaccination delivery system and sustainability of the service are hence partly linked to the effectiveness of the adaptation strategies of the health system agents, particularly those at the peripheral level.*

*This resilience masks the real challenges that a proactive strategy for strengthening the health system should have targeted more directly.*

One of the areas of intervention specifically focuses on strengthening of supply systems. Our fieldwork interviews suggest that certain needs were not covered by the intervention. At the most peripheral level – health centres – the logistic chain on which the success of immunization activities hinges appears fragile, sometimes even lacking. The equipment pool necessary to maintain the cold chain functionality is obsolete (7 to 8 years of average age for the refrigerators used in CHSP whose model no longer exists). The cold chain is also particularly exposed to energy and transportation issues. Problems also surface on the arrival of new vaccines whose packaging is more voluminous. The motorized logistics is also confronted with serious problems and the resources required for the maintenance of infrastructure and equipment is inadequate. The functioning of the logistics chain also depends partly on the goodwill and commitment of the agents, who would need to use their own means of transport, make several back and forth trips for transporting vaccines in order to overcome the inadequacies in the transportation and storage capacities, and "replace the old refrigerators", etc.

#### 4.2.3 Analysis of the relevance of DQA support offered by GAVI HSS

"DQA" (data quality self-evaluation) is a regular activity reviewing the quality of the immunization coverage data at the health centres for all the districts of the country. It is therefore an activity aiming at strengthening the immunization services. The support to DQA activities thus logically falls within the scope of the GAVI HSS initiative. However, this activity already benefits from GAVI funding of Expanded Program on Immunization (EPI) undertaken by the Ministry of Health and other partners.

Moreover, without undermining the improvement in the immunization coverage in the time-period reported by population surveys, the problem of the quality of data used for the estimation of immunization coverage rate in the NHIS endures. The vaccine coverage rate regularly exceeds 100%, sometimes by a considerable margin. Despite the "gaps" in this coverage, the denominators used for calculating these indicators are not "well-understood". The DQA, as it is carried out, is hence not effective enough.

Owing to other programs funding this activity, including the one supporting another GAVI initiative, and the quality of data used for calculating the immunization coverage rates, the relevance of support to DQA within the framework of GAVI HSS, as has been extended in recent years, is questioned by some stakeholders of GAVI HSS and the evaluation team. For the latter, it seems important that innovative activities be initiated for this support program in order to target the real bottlenecks pertaining to the problem of quality of immunization data. The returns from such an innovation will be considerable as this is a national problem.

#### 4.2.4 Potentially innovative initiatives within the GAVI HSS framework

Two pilot projects accounting for almost 5% of the total budget were undertaken (table 2). These involve 11 villages of 3 health districts and consist of the following activities:

- (1.8) developing a pilot model for offering maternal and infant health care nearby, through the communities in 3 villages in 3 districts over 3 years;
- (1.9) supporting the creation of 8 obstetric emergency management cells in the communities in the districts of Zabré, Léo and Pô.

Here again, the link with immunization activities is only moderately preserved. The lack of information (absence of strategic documents, activity and result reports, mobility of players, etc.) has prevented the team from analysing the adequacy of these strategies. We would look at the implementation of these activities in the process analysis.

Moreover, the support request provided for four operational researches representing a little less than 2% of the total budget (table 2):

 (1.10) carrying out an operational research on reference and counter-reference in two pilot districts
(Orodara and Fada Ngourma);
 (1.12) conducting an operational research on epidemiological monitoring in 5 HFs of 5 different HDs
(Ouargaye, Pô, Banfora, Dano and Batié);
 (2.6) supporting the implementation of an action research in the EPI domain in 5 HDs with low EPI indicators (Séguénéga, Kombissiri, Sapouy, Nongremassom, Dandé and Gayérie);
 (3.3) conducting an operational research on community-based epidemiological monitoring (SEBAC) of diseases targeted by the EPI in 6 HDs with low EPI indicators (Séguénéga, Kombissiri, Sapouy, Nongremassom, Dandé and Gayéri).

The team is of the opinion that the inclusion of action researches targeting the identified bottlenecks and those impediments for which the national authorities do not have proven solutions is an excellent initiative. The implementation of action researches figures among the acknowledged best practices for the resolution of problems for which the solutions have not been readily identified.

The subject of implementation of these action researches is dealt with in the process analysis section.

#### 4.2.5 GAVI HSS, a financial framework to address the unmet needs of the health system

In practice, GAVI HSS is mostly perceived as a financing mechanism striving to address the unmet needs of the health system and taking measures where there is a need to act without delay. The list of major planned activities can be referred to below:

 Provide financial support to districts for the implementation of the strategy to seek out persons with whom contact has been lost for preventive and curative activities (63 HDs);
 Carry out quality control of routine data in health facilities every six months;
 Review the media and mechanisms for collecting health data within the Health Information System;
 Provide financial support to 10 HDs with meagre financial resources for the integrated monitoring of MPA activities at the CHSP level;
 Support the health information system in the collection, analysis and dissemination of statistical data;
 Provide 5 newly created HDs with an initial supply of Essential Generic Drugs (Pouytenga, Bittou, Léna, Baskuy and Karangasso Vigué).

Hence, the specific value added or the “signature” of GAVI’s support to health system strengthening is not that apparent to clearly demonstrate.

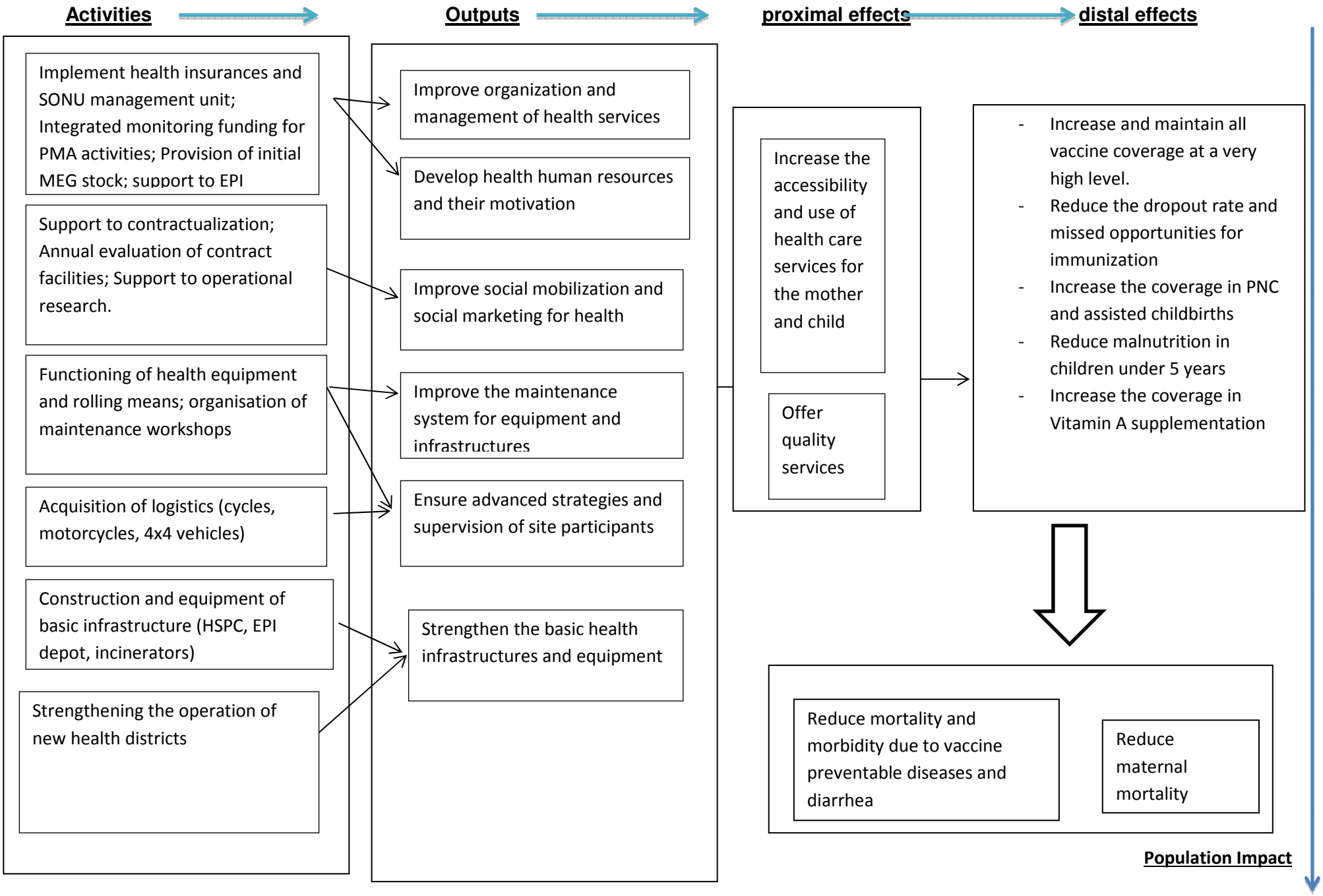
## 4.3 TO WHAT EXTENT WAS THE CONTENT OF THE SUPPORT REQUEST MADE BY BURKINA FASO TO GAVI BASED ON A CLEAR THEORY OF CHANGE WITH STRONG LINKAGES BETWEEN PLANNED ACTIVITIES AND THE IMPROVEMENT IN THE IMMUNIZATION PROGRAM?

### 4.3.1 Difficulty in linking the intervention rationale with the theory of change centred on immunization

The linkages between the intervention areas and the immunization activities have been more or less maintained. The share of resources allocated for activities specifically targeting the organization of immunization services is only 8% whereas the portion allocated for activities with no direct link with immunization is about 85%. The remaining 7% has been reserved for activities with direct impact on both immunization and other intervention programs.

The team has reconstructed the implicit theory of intervention (before its implementation) by scrutinizing 44 main activities, the selected intervention areas and other documents (figure 5).

**Figure 5:Implicit intervention theory**



This approach is essential in the context of evaluating the short-term, medium-term and long-term results of the intervention or the attribution of certain effects to specific components of the intervention.

However, it is not said that this consistent attempt to regroup strategies of actions laid out, actually corresponds to the spirit in which the content of the application was prepared. In fact, as we have seen, the selection of intervention methods relies more on the need to deal with bottlenecks and unmet needs than a standard planning process to involve the health, services and resource requirements, in an articulate and consistent manner.

The GAVI HSS intervention reasoning is characterized by which is certainly still possible to with immunization activities but are still, on the whole, not very specific to them.

The inclusions of activities targeting the health insurances, management unit for obstetric and neonatal emergencies, provision of medicines, are some examples. These activities, when efficiently completed, undoubtedly contribute to strengthening the health system. But in the specific context of Burkina Faso, it is difficult to connect them directly to a potentially measurable change in vaccine coverage. In other words, the intervention theory is difficult to be connected to a change theory focused on immunization.

*Therefore, in general, the examination of the application shows that GAVI HSS targeted many needs and bottlenecks limiting the capacity of the health system. But the link with the immunization services and benefits that they could derive are not necessarily tangible. In other words, the strategic choices made, do not exclusively target "priority obstacles to the accomplishment of immunization and other interventions for maternal and child health" appearing in the GAVI HSS guidelines 2007.*

#### 4.3.2 A fragmented intervention model less specific to immunization

The intervention is also characterized by a large diversity of activities that makes it fragmented: health management, training, construction, equipment, materials, inputs, maintenance, etc. This fragmentation was often described as “scattering” by the stakeholders and reduced the readability and identity of the intervention.

The apparent fragmentation is reinforced by the co-existence of national and local actions, the selection of certain districts with special needs (under-financed or newly created districts) and restriction of local actions in the territories, health facilities or specific communities in target districts. Finally, the intervention model has a limited perspective of the districts and concerned communities.

The consideration of a varied range of intervention areas and coverage of practically the entire health pyramid is understandable. The requirements of the health system strengthening are several and diversified. By focusing on problem solving and responding to unmet needs (which is not at all negative), the strategy prepared “restricted” most of the interventions for targeted actions for certain districts, communities or specific facilities. Also note that, contrary to the conditions of the last application (second phase being launched), the GAVI HSS proposal, in its first version, did not explicitly mention “health system strengthening for immunization”.

#### 4.3.3 Continuous ambiguity on the nature of GAVI HSS

Several stakeholders of the national party find the concept of “GAVI HSS” ambiguous. Is GAVI HSS a “response project” or a “funding body” with the aim of responding to requirements that are not met by the healthcare system and that require prompt action?

- If it is a project, the consistency of the entire response mechanism grouping together objectives, response strategies, activities and resources is fundamental for its legibility as well as its accountability.
- If it is mainly a financial instrument (a “fund”), the intervention logic is secondary to the objective of ensuring the effective mobilization of resources for systemic actions that are high in priority but potentially disparate and fragmented.

The difficulty is that GAVI HSS simultaneously displays the characteristics of a fund and a project. This dichotomy creates and maintains considerable confusion regarding what it does, should do, or can do.

The message and the objectives of GAVI with “GAVI HSS” are not perceived clearly. GAVI doubtless has a precise vision of GAVI HSS and the position of the HSS system in the range of interventions that GAVI offers countries to aid immunization. But on the field, the situation is different. The status is not understood properly, all the more so because:

i) the association with immunization is not always maintained, as we have seen;

ii) the alignment with the other elements of GAVI intervention in Burkina Faso is extremely limited due to, among other factors, the low level of involvement of the DPI in the implementation and/or monitoring of GAVI HSS;

iii) The GAVI HSS concept itself is ill-defined, creating an ambiguity between funds and project, and ultimately leading to contrasting understanding and expectations according to the concerned stakeholders.

The stakeholders interviewed therefore understand GAVI HSS differently. At one end of the range of perceptions, a group of local stakeholders perceive GAVI HSS "only" as a fund to carry out priority actions targeting needs that have not been addressed. Here, the coherence of the intervention is less important than its ability to resolve day-to-day problematic situations and prevent bottlenecks that can harm an organization or the delivery of services. At the other end, GAVI HSS is considered an "intervention project", that is a collection of tools employing coherent comprehensive strategies with a well-defined goal.

## 4.4 TO WHAT EXTENT IS THE CONTENT OF THE APPLICATION FOR SUPPORT BY BURKINA FASO BASED ON A SOLID ELEMENT OF MONITORING AND/OR EVALUATION?

### 4.4.1 Integration of the implementation, monitoring and reporting system of GAVI HSS with a major role for HDSP and none for the DPI

Since the implementation of GAVI HSS was comprised in the NHDP, the management of its implementation obeyed the same logic. The Health Minister did not opt for the establishment of an autonomous project management body and instead opted for its integration within the framework of the implementation of the NHDP.

The responsibility of implementing GAVI HSS was given to the Director of Studies and Planning (DSP, now DGSSS) and the coordinator of HDSP, financial management to HDSP and coordination, monitoring and evaluation to the monitoring committee of NHDP in its role as the Health Sector Coordination Committee (HSCC).

*The pooling of resources mobilized to achieve the objectives of the NHDP is the essence of HDSP and since most of its donors are in agreement with the processes for raising funding appeals, disbursement, reporting, verification etc. the choice of the Ministry of Health seems appropriate.*

The funding, monitoring and reporting of activities implemented in the fringes of the healthcare system follow a routine based on the action plans of the regions and districts that function at the level of ST/NHDP and HDSP.

The management of activities at the central level was not specifically mentioned in the GAVI HSS submission.

The DPI is not included in the monitoring mechanism for the implementation of GAVI HSS, which may work against the necessary convergence between the support strategies for immunization expected from GAVI HSS and immunization activities.

Since HDSP is responsible for financial management, it was also expected that the approval of activity and financial reports of GAVI HSS should be provided by the steering committee of the same HDSP[19]. Besides its technical resources specializing in financial management, HDSP also has the necessary technical resources for monitoring, evaluation and even procurement, which are necessary for "large-scale" activities, including construction, equipping, the purchase of medical supplies etc. planned by GAVI HSS. The duties and responsibilities of HDSP are therefore important and relatively clear.

[19]GAVI Alliance/Government of Burkina Faso, *ibid.,* pg 46

However, the duties and responsibilities of the DSP have not been specified apart from the division of responsibilities related to monitoring, evaluation, and approval and the relationship between HDSP and the monitoring committee of the NHDP, which plays the role of the Health Sector Coordination Committee (HSCC) in the proposal document.

*These gaps in the definition of the terms of reference of these bodies and their relationships with each other within the framework of GAVI HSS involve risks. We will see the result of this during the implementation of GAVI HSS during the analysis of the processes.*

#### 4.4.2 Progress indicators

GAVI HSS has six impact and outcome indicators:

1. National DTP-HepB-Hib3 coverage
2. Number of districts attaining 80% DTP-HepB-Hib3 coverage
3. Mortality rate among children aged below five years (per 1000)
4. CPN2 coverage rate
5. Rate of assisted delivery
6. VAT2 coverage among pregnant women

The first three were selected by GAVI and the last three by the Ministry of Health.

According to the evaluation team, the indicator on infant-juvenile mortality is not relevant under the circumstances. The limited scope of intervention cannot reasonably lead to measurable changes in mortality rates. This indicator should be removed from the set of indicators chosen by GAVI.

The indicators added by the Ministry of Health are aligned with the principal objectives set out in the proposal:

- Increase in the accessibility and utilization of healthcare services for mothers and children in the GAVI HSS proposal;

- Improvement in immunization and other healthcare services for mothers and children.

However, we estimate that these provide little information under the circumstances:

- None of these indicators concerns the health of the child; their face validity is limited;

- These indicators are universal. They are at the end of a series of several processes related to regulation, organization and delivery of services. They are not specific enough to be used directly for purposes of evaluation or evaluation of GAVI HSS results;

- Considering the limited scope of intervention, their sensitivity to changes is insufficient, even for an analysis, which will be limited to specimen districts.

GAVI HSS has six activity indicators:

1. Proportion of health districts on which an LQAS evaluation has been performed;
2. Proportion of functional pilot sites offering neighbourhood maternal and child healthcare services;
3. Proportion of HSPC workers trained in healthcare planning;
4. Proportion of HSPC constructed and equipped;
5. Proportion of maintenance workshops constructed and equipped;
6. Proportion of CMAs provided with an ambulance for medical evacuations.

These six indicators concern the objectives and activities planned under GAVI HSS. However, with the exception of the second, they all are related to outputs rather than results. They are therefore more informative for monitoring-evaluation purposes than an

assessment of the impact of these activities on capacity for action.

Note that none of these activity indicators are related to the GAVI HSS focus area "Strengthen social mobilization and marketing for the areas with low utilization of immunization services".

Summary of analysis of the relevance

The intervention is consistent with the series of actions for strengthening the healthcare systems supported by GAVI. The aim is to improve and maintain a high level of immunization coverage in the countries through the strengthening of the capacity of the healthcare system. However, the different stakeholders understand GAVI HSS differently. GAVI has a specific vision of its approach for strengthening healthcare systems and of the position of HSS in the range of interventions supported by the organization. This position is not well understood by local stakeholders, particularly in the periphery. Their understanding is all the poorer as the association with immunization is not always maintained, the alignment with the other elements of GAVI intervention in Burkina Faso is limited and the concept itself is ill defined by national stakeholders.

The principles of alignment have been respected; the national party has laid out the design of the intervention and the strategic and operational strategies. The programming choices take into account the systemic requirements and are aligned with the National Health Development Plan (NHDP 2001-2010). They are aligned with the national strategic orientation. The decision of the Ministry of Health to allocate financial management to HDSP on the one hand and coordination, monitoring and evaluation on the other hand to the monitoring committee of NHDP in its role as the Health Sector Coordination Committee (HSCC) is in line with the institutional arrangements agreed with the partners.

The areas and levels of intervention selected and the health districts observed were effective responses to national priorities. GAVI HSS overall targeted the requirements and bottlenecks limiting the capacities of the healthcare system. However, the strategic choices made do not exclusively target the "priority obstacles impeding the accomplishment of immunization and other interventions for the health of mothers and children" which was one of the directives of GAVI HSS 2007.

Unquestionably, a link with immunization activities is still possible. But, the activities remain less specific than these. As per the guidelines, the link between the immunization activities is more or less maintained. Intervention is characterized by a large variety of activities that make it appear relatively fragmented.

Intervention is chiefly scheduled around the response to unmet needs and structural or circumstantial bottlenecks. It is therefore only partially connectable to a theory of change focused on immunization.

The resources allocated to the different areas of intervention vary. Two areas – "Improvement in the organization and management of healthcare services" and "Strengthening of basic infrastructure and equipment in the least served areas" – account for two-thirds of the budget. The activities that received the largest allocations,

that must a priori receive the most careful management, are the construction of health centres and rendering them operational.

The indicators of progress are in line with the principal objectives and activities of the request. But they are not sensitive enough to change and are specific to intervention activities.

# SECTION 5 | PROCESS ANALYSIS

i) To what extent were the activities included in the HSS proposal implemented as planned (quality, quantity, methods)

The process analysis covers respectively: (1) the accuracy of the intervention; (2) the organization, management and monitoring of activities; (3) utilization of resources and (4) interaction with the GAVI secretariat and the technical and financial partners. It is based on a qualitative methodology, using data from the combination of information from documentary sources (annual reports, correspondence), interviews with stakeholders from the central and peripheral levels and observations made in specimen districts. The subsequent discussions with the Ministry of Health have enabled, when required, the specification of certain aspects of the analysis.

## 5.1 ACCURACY OF THE INTERVENTION

The evaluation concentrates on the presentation of the activities implemented, modifications made and the potential gaps in the initial programming. It is based on the triangulation of information from documentary sources (annual reports, correspondence), interviews with stakeholders from the central and peripheral levels and observations made in specimen districts.

The satisfactory completion of annual reports and the detailed knowledge shown by the focal point of the project made this evaluation much easier. Certain details could not be provided, principally those concerned with low-level activities or carried out at the beginning of the project. However, we are confident overall with the fidelity and the relatively exhaustive character of the information collected.

The effective implementation of the intervention started in 2009 and not 2008 as planned. The GAVI Alliance and GAVI Fund Board approved the request on June 26, 2008[20]; funds were received in September 2008.

It was observed that the nature of the intervention and great diversity of activities contribute to its fragmented character. The range of activities supported by GAVI-HSS simultaneously covers responsibility for health, training, construction of front-line health facilities, provision of equipment, material and other supplies, and maintenance support. We will successively examine the degree of implementation of these activities, one objective at a time[21]. At the end of this section is a detailed presentation, in the form of a table (table 6) of the level of implementation “for each activity”.

[20] GAVI Alliance: Decision letter on the proposal for health systems strengthening to the Ministry of Health on August 14, 2008.

[21] As a reminder, the 5 objectives of the project are: (i) improving the organization and management of healthcare services, (ii) developing human resources for healthcare, (iii) strengthening social mobilization and marketing for areas with low utilization of immunization services, (iv) improving the maintenance system for equipment and infrastructure and (v) strengthening of basic healthcare infrastructure and equipment in the least served areas.

### 5.1.1 Improving the organization and management of healthcare services

The first intervention area covers 19 activity groups (table 8, objective 1). The focuses are as follows:

The majority of activities included under this head concern the support of organization and management of healthcare services. These activities are planned and implemented annually by the health districts. The project therefore supports the regular implementation of plans, and the inclusion of activities in the "routinized" processes in the districts has aided their completion and the fidelity of their implementation.

- Generally speaking, stakeholders – particularly field workers – express a positive reaction to the activities that they consider relevant, since they are in line with their needs. These are, among others, support in finding patients lost to follow-up, review of supports as well as data quality control.
- The revision of information materials and health data collection mechanisms of the information system are appreciated and there is a demand to continue the support provided: "the support provided to the revision and creation of material for management and monitoring of EPI diseases, guide to restocking of supplies, vaccine management records, tick registers etc. made all these tools available and accessible in all the HSPC."

However, activities associated with monitoring indicate otherwise, particularly from the central level (evaluation of the implementation of the intervention, mid-term evaluation, annual review meeting, periodic field visits, final evaluation), which, as demonstrated in table 6, tend to be less in line with the initial planning. A single round of monitoring[22] of the implementation of GAVI owned activities was carried out, in the name of the Directorate of studies and planning (DSP now DGSSS), in October 2010. It mobilized four teams and was in response to a specific request by the GAVI secretariat *"it was GAVI that sent a mail to bring our attention to monitoring"* and subsequent visits were not carried out. *"We wanted to carry it out again in January 2011 but did not do so. The one visit is considered in the report as mid-term evaluation"*.

The central level preferred to use the monitoring performed by the districts and sessions on funding and adoption of action plans. Indeed, in the different annual status reports sent to GAVI, it was always mentioned that: *"the monitoring and evaluation is done within the framework of the existing system: every six months, the health districts monitor the activities and carry out integrated supervision of the health workers. The central level carries out mid-term evaluations of the action plans for the current year and a final evaluation during the adoption and funding of action plans for the following year"*[23]. Some interlocutors from the peripheral levels also indicated that they would have liked a stronger presence of teams from the central level: *"they do not come any more to supervise; but they should come to see our weaknesses and encourage us"* (respondent – regional level).

[22]Annual status report 2010

[23]Various annual status reports (2009; 2010; 2011; 2012) GAVI RSS

- For several persons in charge from the Ministry, the value added by the specific monitoring by GAVI-HSS is low because the Ministry already has its own monitoring system (monthly HSPC reports, quarterly reports from HDs and RHD, half-yearly status reports from HDSP). The following statement by a person in charge from the central level to whom a request for a field visit was submitted illustrates this perception: *"this is an income generating activity (IGA), if you visit the field, there is nothing to see, and it has no significance"*. This position will be reaffirmed during a consultation meeting *"the TDR for monitoring visits of GAVI HSS; Well, IGA means we need to go there to fill our pockets; the activity does not add any value"*.

- It therefore appears that one is limited to proceeding with the aggregation of data from different bodies involved (HDSP, DPI, DPSSS) for preparing the progress reports required by GAVI.

- In the absence of an institutional anchorage specified by HSS, the organization of visits related to these activities is limited by the difficulty in mobilizing persons and teams that need to make these visits.

The creation of a pilot model for provision of local maternal and infant healthcare services under the communities in three villages was cancelled. This cancellation is due to the complexity of the model that was to be established, according to the in-charges.

In contrast, the units for the management of obstetrical emergencies under the communities were set up successfully: this activity additionally being in accordance with the national policy of the Ministry of Health that all deliveries should be assisted by qualified staff. It was however reported that the efficacy of these cells is limited due to the absence of bicycles which should have been planned to enable community health workers to travel to the health centre: *"as you don't have anything (means of transport) to help the woman to reach the health centre, when she is about to give birth, her family does not even inform you; since this change, we are more welcome in the village"*.

When progress goes as planned, the management cells model contributes to an improvement in the level of assisted deliveries. However, pregnancies and childbirths missed by the community health workers, due to, among others, transport-related reasons mentioned, are particularly problematic. When the delivery takes place at home, the community health worker is not informed about the birth, and in turn cannot inform the staff in the health centres and the child is at risk of not being immunized during the advanced strategy visits: *"the problem faced by the cells for management of obstetrical emergencies is that when things do not work out, deliveries are done at home, which creates a problem in terms of immunization, since the healthcare worker in the HSPC does not have any control over the child"*. (Member of a district management team). Therefore, although the approach is not really questioned in terms of funds, it appears necessary to refine the content and process to make it more efficient.

*i) The implementation was flexible; indeed, with the difficulties forecast during the implementation of certain activities, adaptations were made, mostly by abandoning certain activities.*

*ii) The main outcome is the effective implementation of routine activities at the peripheral level with positive reactions from the beneficiaries.*

*iii) The effective implementation of routine activities at district level offered a realistic opportunity to improve the immunization coverage. The strengthening of the data collection process, the search for persons lost from view, orientation of the role of community health workers as well as health insurance offer through different mechanisms the possibility of reaching the target populations more successfully and improving the coverage.*

*iv) For some activities, additional measures are required to improve their effectiveness and the effect on immunization services: strengthening the operational capacity of community health workers, improvement in health insurance subscriptions.*

Activities to support health insurance were completed as planned. Field workers have a positive image of health insurance as they increase the visits to health centres for curative consultations and consequently create an opportunity for health workers to catch up with children who had missed being vaccinated. "*With insurance, parents do not worry about money… we observed in village X, that even if a child has a minor health problem, they bring him for consultation and the health worker uses the opportunity to verify his health card and catch up with the immunization as required; but in the absence of insurance, parents hesitate a lot and resort to self-medication without consultation. It is because of health insurance that the HSPC in village X is visited often*". (Head of a management team; former head nurse).

### 5.1.2 Developing health human resources

The second intervention area covers six activity groups (table 8, objective 2). The highlights are as follows:

With one exception, the activities intended for the development of health human resources were all implemented during the two years when they were initially planned. Whether the activities involved were relevant to the peripheral level or the centre. Only the implementation of the activity "Support in the implementation of an action research in the EPI domain in 5 districts with weak EPI indicators" was only partially achieved.

The awarding of prizes to the best health centres was a great success. Our interlocutors who consider it a tangible source of stimulation for the local teams value it. Health workers also appreciate it, considering it as a recognition of their work that they would like to see reinstated: "*I was awarded in 2009, but since 2011, the activity has been stopped though the workers wish for it, since it gets them to compete*" (HSPC agent).

The plan for strengthening the skills of community workers is associated in the districts visited with the adoption of the new role of community workers (village birth attendant, community health worker). Regarding the training of health workers, the support of GAVI HSS in these training activities is recognized by the field workers as "beneficial" and the discontinuation of these activities is regretted: *"the presence of GAVI HSS enabled us to organize meetings between EPI officials and the district management team (DMT), where discussions on the difficulties they faced on the field were held, in terms of planning of activities as well as their execution. But after GAVI HSS was discontinued, we no longer have these meetings, while the EPI officials are often people who come straight from school as a result of staff mobility; these workers need strengthening of their skills; it is true that we conduct supervisions, but they are not enough to train them adequately"*.

Activities focused on professional training institutions (orientation of trainers, curriculum revision) were achieved at the end of the intervention (2010). In the absence of an evaluation for the agents trained on the basis of these new curriculums, it is not possible to comment on the quality of the training sessions or their efficiency. One can nevertheless conclude that, in theory; the activity seems relevant, targeting the training of new workers arriving in the districts with poor skills in immunization. According to one of our interlocutors, *"the problem faced by new workers is mainly the lack of skills in the maintenance of EPI refrigerators"*.

*i) The level of accuracy of the implementation has risen. The only aspect with shortcomings was "research" which was only partially implemented;*

*ii) The awards to deserving HSPC is a well-appreciated experience and its continuation should be considered;*

*iii) The efficiency of training and curriculum revision activities should be evaluated.*

The action research was recognized as a channel which, for example, enabled a district to resolve a problem related to the insufficient utilization of immunization services: *"We observed that in one of our rural HSPCs, the immunization coverage was poor, therefore we conducted an action research with the support of the RHD. This enabled us to find out that there was a problem with the*

*organization (long waiting time, reception, communication). Following this we met the entire staff and requested a reorganization of immunization activities during which the district management team conducted an evaluation; in this way we succeeded in raising our immunization indicators"*. (District head doctor). This said, apart from this specific example, we do not have sufficient factual data to comment on the quality and the real value added through operational research carried out at the district level.

#### 5.1.3 Strengthening social mobilization and marketing for the areas with low utilization of immunization services

This third area of intervention covers 4 groups of activities (table 8, objective 3). The highlights are as follows:

All the activities were adopted as planned, with the exception of "annual external evaluation of the contracting structures for social mobilization" which was carried out only once. However, some interlocutors regularly question the relevance of certain activities carried out through contracting. This is with respect to funding of technical support, monitoring and evaluation of work contracted with community-based organizations for implementation (CBO) in districts with poor immunization coverage.

The problem exists at various levels:

i) Immunization activities are not involved with the existing contracting arrangements. Contracting is oriented on priority towards areas such as HIV/AIDS (mainly for the prevention of mother-child transmission), tuberculosis and malaria (through the support of the Global Fund). As stated by a representative of a community based organization, *"if the CBO do not carry out activities for awareness on immunization, it is because there is no specific package for immunization as there is for nutrition, HIV and tuberculosis"*;

ii) Contracting is considered an exogenous, unsustainable activity: *"the major problem with contracting is that when funds are exhausted, the CBOs do not function anymore and it appears that they have lost motivation or there are money-related issues!"* Member of a district management team (DMT).

iii) Contracting is perceived as a parallel process competing with the community health workers (CHW): *"those who get left behind at the community level are the CHW, since these are persons who voluntarily do all the work for promotion of health"* (EPI in-charge). According to a regional director *"our CHWs do good work, now that there is money, others are called in to do the work, this has destabilized the system somewhat"*.

iv) The pilot activity of contracting of NGOs allocated the task of strengthening of skills (NGO CAPBD) and the OCBE continues to be very centralized. The OCBE are rarely included at the community level. The situation does not help at all with the local integration of contracting: "the OCBE stays in the main city of the district, recruits animators in this city. To increase awareness in a village X, the animators are sent to this village to carry out their awareness spreading activities, they report to the head nurse who entrusts them to the CHW of village X" (in-charge of an OCBE).

The activity “to carry out operational research on the epidemiologic monitoring at community level (SEBAC)” implemented for example in the health district of Sapouy involved the district management team, healthcare workers of the HSPC and the community stakeholders responsible for the implementation of SEBAC activities. It helped in the formulation of recommendations to correct the gaps, which were identified in order to strengthen SEBAC in the district.

For the “train 8000 community based healthcare agents” activity, our interviews in the concerned specimen districts confirmed the activity but the evaluation team was not able to access the documentary sources to analyse these activities deeply (terms of reference, curriculum, activity and results reports, etc.).

#### 5.1.4 Improving the maintenance system for equipment and infrastructure

The fourth area of intervention covers 7 activity groups (table 8, objective 4). The highlights are as follows:

The problem of maintenance is recurring in the healthcare system, and the choices made regarding this head are unanimously judged pertinent. In practice, many activities planned respond to the requirements that are considered critical.

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*i) The degree of implementation of activities that contribute to this objective is high with respect to the achievements. In effect, apart from the annual external evaluation of contracting structures for social mobilization, all the other activities planned were implemented.*

*ii) The relevance for GAVI HSS of supporting these activities of social mobilization and marketing should be seriously reconsidered. For example, when implemented, the activities have questionable efficiency and the least that can be said is that their local acceptability is low. They do not target immunization activities and even if they were efficient, their strengthening would probably not have much effect on improvement of immunization.*

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The purchase of a maintenance vehicle was planned for the directorate of infrastructure, equipment and maintenance. This vehicle should enable the backing of decentralized structures. The initial acquisition was replaced by the purchase of a 4x4 vehicle: “during GAVI1, we had planned the acquisition of a maintenance vehicle (converted) for the work, but instead a Prado 4x4 vehicle was bought which was used by the director”. There is no justification to our knowledge for this change in the type of vehicle.

The originally planned building and equipping of a Department of infrastructure, equipment and maintenance (IEMD) was partially implemented, very late and chaotically. The same applies to the building of three maintenance workshops. Indeed, the tender for the construction of the IEMD office and the three maintenance workshops was issued in April 2011, that is, over 2 years after GAVI HSS started (2008). The tenders and recruitment of the monitoring committee for the construction of the office and the workshops were only completed in April 2012.

Regarding the importance of maintenance for the efficient functioning of immunization services, a service for infrastructure, equipment and maintenance (IEMD) and functional maintenance workshops, can, in principle, contribute to improve the national immunization program. However, the team agreed that the choice of interventions should take into account the recurrent difficulties that the Ministry of Health faces in effectively rendering this element operational; difficulties apparently closely associated to the instability of competent staff for the management of IEMD and the periodic renovation of equipment.

The office of the service for infrastructure, equipment and maintenance and once of the three workshops were pre-approved in February 2013, after several years of delay. The construction of the other two workshops is almost over. But they are not complete.

*i) Certain constructions were abandoned and this flexibility was obviously circumstantial, the funding being made available to the national authorities by other partners;*

*ii) This head is the one for which the gaps in setting up are the most major: substitution of a maintenance vehicle for a supervision vehicle, non-completion of building projects and non-provision of equipment to the buildings constructed.*

*iii) The gaps in the implementation are explained mainly by faulty management of the construction and inability to anticipate needs and limitations in connection with the construction and equipping of the buildings;*

*iv) The team believes that the problem does not lie in the ability of the Ministry of Health to develop its infrastructure and manage a process of constructing and equipping healthcare facilities. Much more sophisticated healthcare establishments have been permanently set up in the country. It questions rather the capacity of GAVI HSS for the management of such responsibilities and their qualification for conducting this construction and equipping projects. The function of HSPD is basically of a financial nature. It does not have the capability required to assume the responsibility of construction. The existence of a monitoring committee or a formal bogy in charge of these activities would have permitted a greater reactivity from all the stakeholders;*

*v) The setting up of the maintenance workshops and the equipping of IEMD constitutes a pertinent option since it can ensure the improvement in maintenance at the health service level. However, the field workers do not consider sub-contracting a relevant option.*

The company abandoned the construction site and the approved IEMD as well as one of the maintenance workshops do not have the equipment planned: “HDSP visited the maintenance building to approve it, at that time it did not have working electricity and the air conditioners had not been tested; also, the equipment mentioned was not present”. A closed tender is being considered by the Ministry to complete the work.

At one point, the services of the Ministry of Health considered outsourcing maintenance. But, considering the opinion of the participants, outsourcing of maintenance activities was not considered relevant in the region or the expertise was not adequately available in the private sector.

The implementation of various construction and equipment activities was considerably delayed. These construction activities included in the initial planning for five HSPC (see next point), a regional office of the infrastructure, equipment and maintenance division (IEMD) and three maintenance workshops at the district level. The tenders, signing of contracts with the selected companies and those responsible for their monitoring, implementation procedures, termination, etc., were executed very late.

The stakeholders have not understood the complexity of the construction activity. The necessary corrections to conduct these construction activities were not carried out. In a context where there are administrative delays and the procedures associated with managing new constructions being complex, the management was inadequate and insufficiently anticipated. The warning channels in case of a malfunctioning observed did not work properly and the central level officials did not seem adequately informed or sensitized of the difficulties encountered.

Construction delays were reported to health officials and GAVI Secretariat. GAVI reacted several times and finally made a written request for HDSP who will update on the constructions and take corrective measures. GAVI has also said that it is open to reprogramming of these activities.

The construction of three incinerators was cancelled as another donor from the common HDSP pool addressed it.

### 5.1.5 Strengthening basic health infrastructure and equipment in the poorly served areas

This fifth intervention axes covers 8 groups of activities (table 8 objective 5). The following are the salient features:

Two types of activities were considered to strengthen the basic health infrastructures and equipment in poorly served areas. They are the implementation of logistical means and construction of health infrastructures. All the activities related to the implementation of rolling stock both at the peripheral and central services were executed as planned.

On the other hand, for the case of construction of HSPC and EPI depots, whose execution was placed under the responsibility of a specialized HDSP service, there was a significant deficit in the implementation. In terms of constructions, the observations are commonly comparable with those completed for maintenance infrastructures. Again, the requirements and constraints related to the construction were poorly anticipated and mismanaged.

- the tender for the construction of five HSPC was completed in September 2010 i.e. 1.5 years after the beginning of GAVI HSS (2009);
- Contracts with the selected companies for construction of five HSPC were signed only in February/March 2011, while the batches were awarded in October 2010;
- The firm monitoring the works was recruited only 4 months after the date (April 2011) planned for starting the construction of five HSPC;
- to deal with the failures in the development of HSPC construction works at Varpuo (batch no. 1 allocated to C.CO.BAT) and Sassamba (batch no. 3 allocated to EMERGENCE), the two companies responsible for the completion of these batches were been formally notified in September 2011 by the firm monitoring the construction works;
- However, it was only at the end of 2013 (i.e. 2 years after the start) that the financial partners of these companies committed to supporting them in completing the backlogs.
- only one HSPC (Sami) of the five planned is being approved. The rate of completion of physical reports of other HSPC increased from 19.63% to 49%.

To address the situation, procedures to terminate three sites were recently initiated. During these procedures, agreements were made between HDSP and banking facilities of these companies, ending these termination procedures. For the fifth site (batch 1), the contract was terminated and new procedures are being prepared to restart the construction.

The construction of five HSPC also encountered more difficulties than the construction of IEMD office and three maintenance workshops. The planned equipment was not purchased. The budget for constructions and equipment was not sufficient. As mentioned before, there was an accumulation of delays at each stage of the process:

i) A year and a half passed between the start of the GAVI HSS intervention and launch of the tenders;
ii) The time between the attribution of batches and signing of contracts with the selected companies was 5 months;
iii) Recruitment of the works monitoring firm took 4 months after the date planned for starting the works.

If the last two delays were due to administrative delays, the launch of the tender was deliberately postponed to await the results of a study on the standard model of a HSPC and CMA depending upon the installation areas at Burkina Faso: "when the project (HSS1 request) was approved, it was found that HDSP had commissioned a private firm for preparing the standard HSPC and CMA models for the benefit of the Ministry of Health. *The ministry of health mapped the country into three zones and wanted to have a standard HSPC by zone, considering the climatic conditions and cultural aspects for the shapes of buildings. At the end of the study (in 2008) we decided to use the results of this study for the construction of five HSPC.* At the end of their study, the private consultants were responsible for preparing standard plans, tenders and technical execution folders and this took time".

You may be surprised to note that the DGSSS was not involved or no more involved in the construction activities while HDSP and GAVI showed some reactivity in the presence of work delays. In fact, the HDSP coordinator organized several meetings for monitoring the construction works and various decisions were taken.

**Table 5: Evolution in HSPC completion rates**

| No. batch | Constructions | APR 2011 | HSS 2012 | Company responsible for | Actions by the companies |
|---|---|---|---|---|---|
| 1 | Varpuo HSPC (Dano HD) | 19.63% | 19.63% | C.CO.BAT | Termination of the contract |
| 2 | HSPC Boulmatchiangou | 26.26% | 45 % | ETOF | Termination procedure, and involvement of a bank |
| 3 | HSPC Sassamba (Mangoda | 36.36% | 45 % | EMERGENCE | Termination procedure, commitment of a bank to terminate the works |
| 4 | HSPC Datambi (Sebba HD) | 28.38% | 49 % | ETOF | Termination procedure, and involvement of a bank |
| 5 | Sami HSPC (Solenzo HD) | 25.11% | 82% | E.T.B | Received |

The vehicle acquired in DPI and whose utility is widely recognized, was stopped at the time of our investigations; it was not repaired due to a lack of appropriate maintenance systems. On the other hand, the 4x4 vehicles received by the districts are well appreciated as, in these districts; these are the only alternative for supervision and supply activities as indicated by a member of DMT: "it's our only supervision vehicle which runs; this is what saves us".

All planned activities were conducted at the logistics level. The nature of this equipment indicates a potential contribution to the strengthening of the health system in general and immunization, in particular. The situation of the vehicle acquired for DPI and which has a breakdown without any apparent solution, however, indicates that the benefits of this logistics are poor.

*i) Again, the deficit in the implementation focuses mainly on constructions and HSPC equipment. We will not dwell on the causes of these difficulties, widely discussed in the previous section.*

*ii) Most of the resources not used in GAVI HSS fall under this implementation deficit.*

### 5.1.6 Accuracy of the implementation: Summary of observations

- The accuracy of the implementation at the local level - region and district - is good. Most of the activities were completed and from what we know, these activities were carried out according to acceptable quality standards; without showing significant failure.
- Activities that were naturally completed and with a high degree of completeness are the activities under the routine annual programming for districts. This integration has fostered a high degree of completeness and restricted the risk of delays.
- The activities that were delayed, not fully completed or not completed are mainly from the central level. Two groups of activities were mainly partially completed: (1) monitoring-follow-up of the intervention; (2) constructions and equipment.

At regional and health district level:

The success of the implementation is mainly by the integration of activities in the district action plans and the flexibility of HDSP procedures enabling the deferral of certain activities, if required.

At central level:

- Quarterly monitoring of the intervention was not considered relevant by the DGSSS who did not want to add a new process to the current monitoring system.
- Preparation and monitoring of construction activities, causing a very low level of budget execution, was not satisfactory (see above).
- Management of problems encountered in terms of construction and equipment failed: according to the stakeholders, these difficulties did not find a suitable forum where it could be presented, discussed and analysed; the mechanisms to "report" them to the decision-making bodies did not work. HDSP and DGSSS have rather worked in "silo". Stakeholders involved in monitoring GAVI HSS (DGSSS, HDSP, NHDP monitoring committee, HDSP steering committee, etc.) did not respond adequately and sufficiently coordinate in partially completing the construction activities during the implementation of the intervention, despite the difficulties encountered.

### 5.1.7. Accuracy of the implementation and contribution to the removal of previously identified bottlenecks

- The prevailing view is that the effective implementation of routine activities in the regions and districts can actually have a positive impact on immunization.
- Some human resource valuation activities are highly valued by the periphery (prize awarded to HSPC). The training and revision of curriculum can strengthen the competencies of the immunization teams. But we are unable to demonstrate the actual efficiency.
- However, most of these activities are "generic": targeting the organization or provision of "general" health services. The activities more specific to immunization

focus on training, rolling stock and maintenance.

- The concentration of GAVI HSS support at the community level, in its current form, is unlikely to promote immunization in children.

- The construction of maintenance workshops, IEMD and their equipment is a relevant option capable of improving the maintenance at health services level.

- The construction of HSPC increases the access to health care and services, including immunization.

*The information, warning, communication coordination and collaboration mechanisms between different services and programs of the concerned MOH did not work well.*

*i) Almost all commitments at local level were fulfilled.*

*ii) Some activities at central level, which proves to be more expensive - construction activities - are still pending completion / finalization.*

*iii) The stakeholders responsible for monitoring the program (HDSP, DGSSS and GAVI) did not respond to the difficulties encountered, chiefly with respect to construction activities, as expected.*

*iv) Planning and management functions were conducted with various levels of success during GAVI HSS.*

*v) A clearer positioning of the coordination team and a better institutional anchoring will be required for GAVIHSS2. The managerial function should be strengthened and highlighted, as discussed in the next point, on improving the technical coordination and communication and decision-making channels. The reporting system should be reviewed for a better response from the decision-makers.*

## 5.2 ORGANISATION, MANAGEMENT AND MONITORING OF ACTIVITIES

### 5.2.1 Organization and management

GAVI HSS does not boast a proper structure in the organizations of the Ministry of Health and is not organized around a project structure. This positioning meets GAVI requirements, or at least, those that the national participants perceived as GAVI requirements. The Ministry opted for a system which integrates at two levels: (1) DGSSS (Exc. DEP) for the technical aspects and (2) HDSP for financial management.

This institutional positioning mainly reports the search for a practical solution for a quick mobilization and less restriction of allocated resources.

- It stems more from a quickly identified ad hoc solution ("I already selected this option when I read the form; I realized that to have a management unit that would lead to a lot of useless information, I got the idea of HDSP, where the information was sufficient to fulfill the financial management component") as a systematic analysis of various possible configurations in existing flow-charts.
- He was informed about what GAVI HSS is, i.e. targeted funds to address the pressing needs (bottlenecks). Thus, naturally, GAVI HSS is found to be structured around HDSP. The request submitted to GAVI was previously validated by the HDSP and GAVI HSS steering committee is managed as the "target funds" by HDSP.

It was decided to designate an "intervention focal point" But, the organizational challenges related to the coordination and anchoring with the technical services of the Ministry and the national health information system, for example, seem to be having been largely under-estimated when starting the project.

An expert from the Ministry fulfilled the function of "interim focal point" for the entire duration of the intervention. But, this position was never standardized by a nomination, which considerably limits its visibility and its margin of action in the centralized and formal administrative context. As pointed out by this participant at the central level: "*to prepare the monthly report, he came here and I am collaborating with him (focal point), but I know that he was never been officially nominated"; he volunteered to do this job; in fact if we nominate him, it will give rise to responsibility, hope you understand!*"

*The division of roles and responsibilities between the DGSS (Exc. DEP) and HDSP was not clearly established. And GAVI HSS suffered from the absence of an unambiguous decision centre, clear leadership and decision-making body within the Ministry.*

Despite the technical anchoring of the program at the DGSSS and its focal point, the monitoring and follow-up of GAVI HSS are in fact concentrated at the HDSP:

- The construction activities are managed by HDSP (specialized service);
- HDSP has technical resources responsible for monitoring/evaluation. DGSSS completed only one monitoring mission specific to GAVI HSS;
- On the other hand, activities conducted at regions and districts are reported as part of the progress reports prepared by ST/NHDP. And the focal point collects the information required to complete the GAVI monitoring reports in these reports.

Although we have not noted a specific antagonism or an explicit desire to exclude the Directorate of Prevention by Immunization (DPI), it is necessary to emphasize its virtual absence in monitoring, implementation and follow-up of GAVI HSS. At least in its early years of implementation.

*GAVI HSS functions independently from the directorate of protection by immunization and consequently, other components of GAVI intervention, which are, under the responsibility of this directorate.*

This major articulation defect results from a de facto distancing of activities financed by GAVI HSS, "territories" covered by the immunization department. Obviously this has not helped the necessary convergence between the immunization support strategy of GAVI HSS and immunization activities. And this has greatly prompted a "fund management" type approach, at the cost of a "project management" approach.

- The term fund management means a financial instrument that can be mobilized for priority actions targeting unmet requirements. The consistency of the intervention considered here is less than its ability to resolve specific problematic situations and prevent bottlenecks that could harm the organization or delivery of services.
- The term project management means a set of resources organized around overall consistent strategies and continuing well-established goals. In brief, GAVI HSS has suffered from being perceived as an emergency fund to address unmet requirements and an unclear institutional anchoring, too separated from the immunization directorate.

*The team is of the opinion that the leadership failure and absence of an unambiguous decision centre for GAVI HSS explains the poor response from the Ministry of Health to the implementation difficulties encountered. This observation was widely discussed during the meeting with the evaluation-monitoring committee and was widely supported by the audience.*

### 5.2.2 Monitoring of Activities

The monitoring activities implemented by the health regions and health districts under the routine operation including integrated supervisions, activity monitoring and a bi-annual accountability report to HDSP. Hence, there is no specific monitoring at GAVI HSS.

#### 5.2.3. Response from stakeholders

The general responsiveness of the project was highly constrained by the absence of a management unit and a regular follow-up on the progress of activities. In this context, the annual GAVI reporting system also showed its limitations in such areas as construction. The evaluation of annual progress reports (APR) from 2010 to 2012 indicates the following:

- APR 2010 (sent in June 2011): the construction activities (especially those of HSPC), were re-planned for 2011.
- APR 2011 (sent in June 2012): the constructions were started in 2011 and are being completed with a completion rate from 19 to 28%. These activities are scheduled to be completed by July 2012.
- APR 2012 (sent in May 2013): a contract with an entrepreneur was terminated. The low completion rate is explained by the "limited capacity of suppliers during the execution of the work and the inaccessibility of some areas during the rainy season".

The first objective of an efficient reporting system aims to enable real-time monitoring of the implementation, anticipate or identify problematic situations as and when they arise and take corrective measures in a timely manner to avoid deficits of implementation. Yet, with the current GAVI reporting system, participants involved in decision-making (HDSP, DGSSS, GAVI) are informed about the progress in GAVI HSS implementation over several months, even a year later, which does not enable an efficient decision-making and avoids loss of resources.

Failing to change the current reporting system, other mechanisms should be implemented to enable all participants to be informed in real-time; they also help to determine the responsibilities of an inadequate responsiveness to deficits of intervention implementation.

Effectively, a GAVI respondent described this situation by presenting two types of alerts that GAVI had: *"where we had an early warning for constructions, it was due to*

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*i) The informal system implemented enabled to successfully ensure the execution and acceptable monitoring of relevant tasks of the peripheral level and activities that relatively require minimal management.*

*ii) But, this system has proved ineffective for the management of more complex and expensive activities.*

*iii) Neither DGSSS nor HDSP had leadership, informational capacity, and even poor response capabilities ensuring a good execution of programming and activity management functions on a day-to-day basis.*

*iv) Failures encountered in construction and equipment management showed how GAVI HSS suffered from a failed institutional anchoring and absence of a management team responsible for management and accountable for its achievements.*

*v) GAVI HSS 2 should overcome these failures and structure around a more efficient system.*

*the 2011 report in May 2012, but we understood that the internal procedures were hanging; the real warning came after the receipt of the 2012 report, when it was discovered that the things did not change much and that the capabilities of the companies responsible for constructions were involved; that's when we decided to understand the situation well during our current mission (December 2013) to take decisions".* As noted above, the format of the monitoring report and its frequency are not enough for an efficient monitoring of GAVI HSS activities.

Regarding GAVI respondents, vacancies for the posts of HDSP and DEP director due to the death of their respective in-charges also had an influence on the responsiveness of GAVI to construction implementation deficits: "There was a period when there was no meeting due to the death of two officials".

#### 5.2.4 Flexibility in the implementation

The design for intervention relies on a multi-year operational programming. This programming is very detailed, and includes the identification of activities to be completed, task groups and identification of funds required for these different activities. The site participants describe this technocratic planning model is by as too rigid, leaving little or no room for change or space for initiatives of regional or district participants. It tends to statute needs and bottlenecks whereas the very spirit of the initiative is to target malfunctions, blocks or bottlenecks which are essentially poorly predictable in the long term.

Our contact persons of the regional directorates and health districts are frustrated due to the lack of flexibility and rigidity of the multi-year programming model:

> *"If we have the liberty to use resources by staying within the guidelines it would have been more beneficial; but when our requirements make us do readjustments, we find ourselves stuck sometimes, unfortunately due to the envelope; there is a lack of flexibility; the ideal would be to remain the GAVI spirit with some flexibility". ..."The last time we met the staff (management or service meeting) to arbitrate, we realized that we had other visions like evaluations, research, but we could not do them; the activities profile is already defined which restricts the taking of initiatives".*
>
> *"Sorry for the term, it is a poor planning that we have, as we have stalled the activities to be conducted and related envelopes and we should execute them even if we have other priority activities that we would have wanted to do; which could be interesting, it was giving us envelops to not exceed, by asking us to propose activities according to our realities as they differ from one district to another; for example our priority at the moment is to control advanced immunization strategies". This situation sometimes leads to double financing and/or to the conduct of irrelevant activities but whose resources "must" be used.*

*This lack of flexibility was expressed in the 2010 report in the following terms: "the non-flexibility of GAVI HSS activities does not enable the site participants to consider other operational activities 28 ".*

The responsibilities of this poor flexibility are shared. For GAVI, there is a procedure to be followed to modify the planned activities:

*"Countries are informed that there is a possibility to re-allocate or re-plan when implementing the activity, when they see that the activity is no longer relevant or is financed by another funding source; when the cost of the new activity is less than 15% of the total budget, the facility is responsible for validating the GAVI HSS activities discussed, then approve and send a report of its decision to GAVI; but if its cost exceeds 15% of the total budget of the request, a re-planning has to be done in this case, then the request is addressed directly to GAVI which again evaluates the proposal".*

On the other hand, the national party estimates that the efforts required for these changes in the activity are significant and involves an expensive and long remobilization. The risks of rejection by GAVI for the cases of reprogramming the request are presented as disincentives:

*"If you change an activity, you can write 2 to 3 pages of justification; if there is no justification, we will create it".*

Moreover, the peripheral level is aware of the fact that nothing should change the GAVI HSS activities and is resigned:

*"When we talk of certain aspects to HDSP they tell us that GAVI is very strict".*

[28] Annual progress report 2010

## 5.3 RESOURCE UTILIZATION

v) The extent to which financial resources were used as planned and efficiently
vi) What are the contextual factors that can explain the rate of utilization of funds received?

Note that the financial envelop for each intervention[29] axes varies considerably. The resources committed in the order of importance, axes 5 (USD 1,517,749), axes 1 (USD 729,939), axes 4 (USD 439,088); axes 3 (USD 141,262) and axes 2 (USD 121,167). The most expensive - and almost the sole - activity that has not been completed are the construction and its equipment (axes 5) and belong to the central level.

Almost all the activities under the responsibility of health regions and health districts were completed between 2009 and 2010. The absorption rate is almost 100% *"the specialty of GAVI HSS is that the funds which are allotted to us are dedicated to the specific activities. Although these activities are not a priority for us at that time, as they are a part of tasks to be accomplished to ensure our sovereign mission in terms of functioning of the district, we execute them and every 6 months, we report to HDSP. During the last two years where we received GAVI HSS funds, there was no balance of funds.* "(According to a chief district medical officer).

The activities designed for the periphery were partially completed during the first two years of intervention, i.e. from 2009 to 2010. After ensuring the acquisition of rolling stock for the centre and periphery, the only resources which could not be used on time for HSS activities included: (i) construction and equipment of HSPC; (ii) equipment of IEMD and maintenance workshop for the Cascade health region; (iii) construction and equipment of two maintenance workshops; (iv) follow-up-monitoring of activities carried out by DGSSS,

All delayed or unachieved activities are under the responsibility of the central level. This deficit in resource utilization is at 32% (USD 1,599,340) of funds allotted for the intervention (see table 5 below).

Given the approval time lines, the period for executing GAVI HSS was postponed for a year even before starting by moving from 2008/2010 to 2009/2011. GAVI HSS effectively started in 2009 but quickly lagged behind. Technically, the intervention was still not achieved in December 2013. The delays have led to adjustments in the disbursement schedule and were revised several times (table 6). If 100% of funds allotted to GAVI HSS were disbursed by GAVI Alliance since 2011 (table 6), USD 2,115,169 was still not used in December 2012[30].

[29] As a reminder, the 5 axes of the project are: (i) improve the organization and management of health services, (ii) develop human resources in health, (iii) strengthen social mobilization and social marketing for areas with poor service utilization rate, (iv) improve the equipment maintenance system and infrastructures and (v) strengthen basic health infrastructures and equipment in poorly served areas.
[30] The budgetary execution status at the end of 2013 is still not available.

**Table 6: Forecast schedules and disbursements made from GAVI Alliance to GAVI HSS**

| Forecast x 3 and executed | 2008 | 2009 | 2010 | 2011 | Total |
|---|---|---|---|---|---|
| GAVI Decision Letter dated 2008 | USD 3,074,000 | USD 1,239,000 | USD 665,500 | / | **USD 4,978,500** |
| GAVI Decision Letter dated April 2010 | USD 3,074,000 | USD 619,500 | USD 1,285,000 | / | **USD 4,978,500** |
| GAVI Decision Letter dated August 2010 | USD 3,074,000 | USD 619,500 | USD 619,500 | USD 665,500 | **USD 4,978,500** |
| Completed | USD 3,074,000 | 0 | USD 619,500 | USD 1,285,000 | **USD 4,978,500** |

The following table details resource utilization per year. Although there has been a constant effort to reschedule disbursements from GAVI, the Ministry of Health was not able to absorb these resources. The resource utilization rate reduced from 61% in 2009 to 26% in 2010 and to become stable in 2011 at 21% (table 7). However, these statistics hide a much-contrasted situation between the centre and periphery.

**Table 7: Distribution of costs per year***

| | 2008 | 2009 | 2010 | 2011 | 2012 | Totals |
|---|---|---|---|---|---|---|
| **Original Annual Budget (Approved proposal)** | **3,073,854** | **1,239,184** | **665,736** | - | - | **4,978,774** |
| Revised Annual Budget | | 1,894,223 | 1,050,203 | 2,624,421 | | |
| Funds received from GAVI during | 3,073,854 | - | 678,693 | 1,284,920 | - | |
| Balance carried over from previous year | - | 3,073,854 | 1,197,227 | 1,394,478 | 2,115,169 | |
| Total Funds available during the calendar year | 3,073,854 | 3,073,854 | 1,875,920 | 2,679,398 | 2,115,169 | |
| Total expenditure during the calendar year | - | 1,876,627 | 481,442 | 564,229 | 457,136 | **3,379,434** |
| **Balance carried forward to next calendar year** | **3,073,854** | **1,197,227** | **1,394,478** | **2,115,169** | **1,658,033** | |
| Funding required for the next year | - | 1,050,203 | 2,624,421 | 606,767 | - | |
| Resource utilization rate perceived | 0% | 61% | 26% | 21% | 22% | |
| CP-HDSP (HSCC) approval | X | X | X | X | X | |

* 2013 data not received

**How to explain these poor utilization rates by the central level?**

A malfunctioning approach based analysis shows that the difficulties encountered in the use of funds stem from various inputs linked to the planning process, decision-making circuits and administrative circuits.

| Factor | Construction, equipment | Follow-up-monitoring of activities |
|---|---|---|
| **Planning process** | i. The complexity of construction through public procurement for an initiative such as GAVI HSS was not sufficiently understood during planning;<br>ii. The non-participation of local participants and an inadequate evaluation, does not help anticipating difficulties and time lines;<br>iii. The usual bottlenecks in this initiative were not considered. (geographical accessibility of | The monitoring process was clearly defined.<br><br>However:<br>i. Inadequate attention (GAVI and by the country) given to monitoring-follow-up of activities, monitoring being focused on annual reports which mainly summarizes and the utility is restricted to intervention management;<br>ii. Inadequate leadership of DGSSS in the monitoring / evaluation process. |
| **Decision making channels** | As explained in point 5.2 (Organization, Management, monitoring of activities) we observed a poor response from various participants to the difficulties encountered:<br><br>i. The decision-making channels were limited due to the absence of a management unit and a regular follow-up of progress of activities which strongly restricts the general response of the project;<br><br>ii. The annual reporting system is not favourable to real-time | The institutional mechanisms for communication and coordination did not work in an efficient manner.<br>i. Poor coordination: operating in silo (HDSP - DEP) without accountability;<br>ii. The warning function was a failure: no warning bell was sent by the steering /NHDP or HDSP monitoring committee responsible for validating GAVI HSS activities.<br><br>Despite the theoretical technical anchoring of the program at DGSSS and its "focal point", the monitoring and follow-up of GAVI HSS program is concentrated at HDSP. Inadequate leadership of DGSSS. |
| **Administrative channels** | The administrative channels are slow (tender, signing of contracts with selected companies and those responsible for their monitoring, notification, termination procedures, etc.). But the procedures are known and the time lines are partly predictable. The actions to be | Even there, the warning functions did not function optimally. |

Whether the collaboration between various directorates of the Ministry of Health concerns construction activities or quarterly monitoring of the intervention, it is mostly restricted to the transmission or aggregation of data provided by various parties involved in the preparation of progress reports required by GAVI.

Poor management of difficulties encountered and incomplete activities illustrate the lack of project coordination: according to the stakeholders, these difficulties did not find a suitable forum for presentation, discussed and analysed; the mechanisms to "report" them to the decision-making bodies did not work. HDSP and DGSSS mostly worked in "silo", whereby the ICC and/or HDSP steering committee did not effectively play its role: no specific recommendation was made to HSS after validating various reports before sending them to GAVI.

Note that for a better monitoring of financial resources provided to beneficiary countries, GAVI installed a transparency and financial responsibility policy (approved in 2008 and used in 2009), which obliges these countries to undergo a financial management assessment (FMA). The FMA terms of reference[31] for Burkina Faso mainly states that:

> "In 2008, the GAVI Council approved the transparency and financial responsibility policy. *This policy, in force from January 1, 2009, states that all GAVI eligible countries should undergo a financial management assessment (FMA) on existing or proposed systems for the management of GAVI cash support. FMA's are conducted at two levels; during a preliminary review and during a mission in the country.* The main aim of FMA is to guide the country and GAVI in selecting the best financial mechanism for GAVI funds and define additional fiduciary assurance activities which could be necessary to address potential risks and weaknesses".

During the first half of 2010, GAVI requested that Burkina Faso should complete the financial management assessment (FMA) for GAVI cash support during which the GAVI secretariat reviewed the financial management mechanisms and evaluated the need for any modifications of the mechanisms, such as additional insurance measures.

"The aide-memoire for the management of GAVI funds to strengthen the Health Strengthening System (HSS) and Immunization Services Support (ISS) in Burkina Faso" published in December 2010 after FMA did not lead to any significant change in GAVI HSS management methods in particular (unlike the ISS program, which underwent several significant changes). It also updates the general terms and conditions in terms of financial management of the partnership between GAVI and the Ministry of Health.

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[31] Preliminary drafts of the terms of reference: Financial Management Assessment (FMA) at Burkina Faso

## 5.4 PARTICIPATION FROM GAVI AND OTHER TECHNICAL AND FINANCIAL PARTNERS

v) To what extent is the commitment and support provided by the GAVI Secretariat and local partners both in the application process and implementation phase was appropriate and sensitive to contextual changes?

This section addressed three issues: (1) a brief presentation of mechanisms used by GAVI in its exchanges with Burkina Faso; (2) a description of the discussion between GAVI and the Ministry of Health in Burkina Faso during the period covered by GAVI HSS (2008 to 2013); (3) GAVI HSS' place in this discussion.

### 5.4.1. Communication between GAVI and the Ministry of Health during the period covered by GAVI HSS

There are 4 types of communication mechanisms used by GAVI: responses to annual progress reports (APR), mails, meetings (work, conferences) and e-mails. The APR and important mails were assessed by the independent review committee (IRC) before the GAVI administration council could take a decision.

GAVI - Ministry of Health at Burkina Discussion:

1. All GAVI funding was reported in the annual progress report. APR of a given year is sent to GAVI in May - June of the next year. 5 to 7 months elapse between the receipt of reports and response from GAVI. As mentioned, this mechanism is more a summary than a formative evaluation and does not react in real-time.

2. During the period covered by GAVI HSS, the other discussion channels were:

   - Participation of the Burkina Faso Ministry of Health to the GAVI partnership forum at Hanoi (2009);

   - Discussions on the preparation of the Financial Management Assessment (FMA) of GAVI activities (2010). A sustained collaboration is established between the Ministry of Health of Burkina Faso and GAVI during the preparation (e-mail exchange). A work session between the Ministry of Health at Burkina Faso and certain GAVI officials helped fix the period for FMA of GAVI activities.

   - Participation of the regional coordinator - GAVI French-speaking countries in the managers meeting of the Expanded Program for Immunization (EPI) at Ouagadougou between March 15 and 17 2010. Making using of her presence at Burkina, she met (March 18 - 19, 2010) the political, administrative, technical and financial authorities of Burkina Faso and the development partners involved in immunization at Burkina.

   - Conducting a meeting in the week of September 17, 2010, with the members of the health sub-committee of the national assembly of Burkina for a communication on

immunization by the regional coordinator of the GAVI French-speaking countries accompanied by the members of the PATH organization for international advocacy for immunization. This meeting promoted a better involvement of authorities in immunization programs.

As we can see, there has always been regular communication between GAVI and Burkina Faso both at political and technical level, beyond formal communications through APR. The table below summarizes a few key elements to report these exchanges.

| | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| **APR sent on** | May 08, 2009 | May 10, 2010 | Friday, June 10, 2011 | June 6, 2012 | May 15, 2013 |
| **No. of HSCC meetings (or equivalent)** | 0 | 5 | 4 | 1 | 3 |
| **GAVI Missions** | As per our information: 5 GAVI team missions took place during the period. | | | | |
| **GAVI Feedback** | E-mails and informal meetings | | | | |

#### 5.4.2. Place of HSS in GAVI exchanges - Ministry of Health

Adopted in September 2007 by the Ministry of Health of Burkina Faso, HSS holds an important place in the exchanges between GAVI and the Ministry of Health in Burkina Faso.

i) GAVI HSS request processing phase: once prepared, the GAVI HSS request was submitted to the GAVI Secretariat on march 7, 2008 for obtaining GAVI support to HSS. After the GAVI IRC assessed the request in April 2008, a clarification request was sent to Burkina. After responding to the questions, the Ministry of Health re-submitted the request to GAVI. Satisfied by the responses from the Ministry of Health, GAVI IRC sent it to the GAVI administrative council who approved the support request.

ii) GAVI HSS implementation phase: in March 2010, a GAVI official discussed HSS[32] with the political, administrative, technical and financial partners of the country during two days (18 and 19 March). In December 2010, an aide-memoire[33] between GAVI and the government of Burkina Faso – through the Ministry of Health – was signed and defined the fund management methods. GAVI suggested monitoring the works, and this was part of the collaboration convention with HDSP. According to HDSP officials in charge of monitoring construction works, this addresses the delays observed on site for the completion of infrastructures. In 2012, GAVI wrote a memorandum requesting an update by HDSP on the physical and financial achievements of constructions and associated decisions.

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[32] Note GAVI/2010/043/March 03, 2010

[33] Aide-mémoire, governing the financial management of GAVI funds for Health System Strengthening (HSS) and the Immunization Services Support (ISS) at Burkina Faso dated December 6, 2010

In 2013, HDSP proposed reprogramming for the batches (construction of HSPC of lot no. 2 and 4 by E.T.O.T and lot no. 3 by EMERGENCE) where delays were observed. They were accepted by GAVI, who required that these reprogramming should adhere to the previously signed agreement.

iii) GAVI HSS2 request processing phase: in March 2012, a new HSS request was submitted to GAVI. In May 2012, it was evaluated by IRC, and then a recommendation[34] of the "New Submission" was adopted and sent to the officials of the Ministry of Health at Burkina Faso. Later, an approval[35] of the GAVI support request was obtained in March 2013.

### 5.4.3. Flexibility and ability for GAVI response

*Knowing that GAVI does not have a direct intervention role in completing the ground activities and considering the exchanges that took place between GAVI and the Ministry of Health, the evaluation team felt that the organization fulfilled its commitments. Moreover, this does not exclude the expectations of certain stakeholders of the nation that could have been high. Few of them clearly mentioned that they desired a more committed presence and more supported interactions with GAVI during the implementation of the program.*

GAVI is not directly involved in executing ground activities. The organization intervenes only indirectly and only in the event of a blockage or obvious malfunction. According to the aide-memoire signed between GAVI and Burkina Faso, modifications could be made to the work contracts and in the annual report that GAVI sends to the country. The fact that the response process relies on APR extends GAVI's response time. However, as said earlier, the temporariness of reports does not promote quick decision. Responses to annual progress reports sent to GAVI take time. Indeed, the Independent Review Committee (IRC) should first evaluate the report before the GAVI Administrative Council approves recommendations. Consequently, retroactive actions and GAVI decisions cannot be immediate.

GAVI's participation to the effective implementation of HSS at Burkina Faso stems from the evaluation of various annual monitoring reports that Burkina sends to GAVI by GAVI IRC. Its intervention consists in requiring clarifications on the inadequate execution of activities and to submit recommendations to GAVI in favour of or against the approval of the report or requested funds. After the April 2011 evaluation, the following comment was made: "*Most of the activities were 100% completed and those which were not, are accompanied with an explanation (problem with the companies[36]). After the evaluation of the newHSS request in 2012, the IRC said that: "according to the IRC monitoring report in 2012[37], there was an under-utilization of HSS funds during the entire duration of implementing the grant. Nevertheless, there have been satisfactory levels of progress in implementing the activities planned in 2011".*

[34] Note GAVI/12/116/dated June 28, 2012

[35] Note GAVI/12/318/implemented on December 13, 2012

[36] GAVI Alliance: Annual Progress Report 2011 from Burkina Faso to GAVI Alliance, Geneva, November 29, 2012.

In the APRs, there are always points allowing presenting the difficulties encountered. However, by examining various GAVI IRC reports, we realize that there is little or no suggestion of a solution to the difficulties (example: in HSS 2010, we read that the regular change in the format of the annual progress report template makes the filling difficult) mentioned.

*GAVI was present alongside the Ministry of Health of Burkina Faso but the GAVI HSS monitoring system through APR fails to take corrective action or real-time strengthening*

#### 5.4.4. Involvement of technical and financial partners

The main partners involved in the health sector were involved and participated regularly to the different key stages of preparing the request. During the preparation of GAVI HSS request, WHO, UNICEF and World Bank representatives contributed to the review of the request: *"They read, commented and revised the document"* (member of the request preparation committee). Several partners (UNICEF, WHO, UNFPA, World Bank, Netherlands) in the NHDP monitoring committee validated the request. The partners in the NHDP and/or HDSP monitoring committee validated the annual progress reports as part of the statutory monitoring defined with GAVI (APRs are validated and signed by the participants before sending them to GAVI). However, note that the monitoring committee of this evaluation has several partner representatives, mainly UNICEF and WHO.

*The partners participate in formal GAVI HSS monitoring processes every year. GAVI HSS1 evaluation team, however, lacks factual evidence demonstrating a concrete involvement or an active commitment in the implementation of activities in line with the different intervention axes or intervention management. Most of our respondents would have preferred a stronger involvement from partners in the implementation of activities, especially the activities that were difficult to implement.*

[37] GAVI Alliance: Request by Burkina Faso to GAVI Alliance, in 2012, for a cash support for health system strengthening; Geneva, March 11, 2013.

**Table 8: Accuracy and intensity of activities in line with objectives 1, 2, 3, 4 and 5**

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| **Objective 1: Improve the organization and management of health services by 2010** | | | | | | | | | | | | | | | | |
| 1.1 | Conduct an annual survey for EPI data validation at HD (LQAS) | | X | X | | | X | P | X | T | | | | | | |
| 1.2 | Financially support the Districts for implementing the strategy in search for the ignorant | | X | X | | | X | P | X | T | | | | | | |
| 1.3 | Conduct external evaluations of the implementation of GAVI activities | | X | X | X | | X | NR | X | P | X | NR | | | | |
| 1.4 | Conduct the quality check of routine data in health facilities, twice an | | X | X | | | X | P | X | T | | | | | | |
| 1.5 | Revise the supports and data collection mechanisms of the Health Information System | | X | X | | | X | P | X | T | | | | | | |
| 1.6 | Financially support 10 HD with poor financial resources for the integrated monitoring of PMA activities at HSPC | | X | X | | | X | P | X | T | | | | | | |
| 1.7 | Support the Health Information System | | X | X | | | X | P | X | T | | | | | | |

**Legend**:
CF: co-financing (Y = Yes and N = No)
* : T (Totally completed); P (Partially completed); NC (Not completed)
**: Budget planned for year X
***: Budget planned for year X

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| | distributing of statistical data | | | | | | | | | | | | | | | |
| 1.8 | Implement a pilot model for providing maternal and child health care within the communities in three villages | | X | X | | | X | NC[38] | | | | | | | | |
| 1.9 | Support the creation of management units for emergency obstetrics in the communities in the districts of Tenkodogo and Solenzo | | X | X | | | X | NR | X | T | | | | | | |
| 1.10. | Conduct an operational research on the reference and counter-reference in two pilot | | X | | | | X | T | | | | | | | | |
| 1.11 | Support the implementation of mutual health insurance in HDs with poor utilization of | | X | X | | | X | T | X | T | | | | | | |
| 1.12 | Conduct an operational research on the epidemiological surveillance in 5 districts (Ouargaye, Po, Banfora, | | X | | | | X | P | | | | | | | | |
| 1.13 | Conduct 2 meetings to assess the implementation of HSS-Global activities every year at the regional | | X | X | | | X | T | X | T | | | | | | |
| 1.14 | Conduct 1 meetings to assess the implementation of HSS-Global activities every year at the national level | | X | X | X | | X | NR | X | NR | X | T | | | | |
| 1.15 | Equip 5 newly created HD in | | X | X | X | | X | NR | X | NR | X | T | | | | |

[38] Difficulty in implementing the activity related to a problem on the institutional arrangements plan.

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| | initial supply of Generic Essential Drugs (Lena, Karangasso, Vigue, Baskuy, Pouytenga, | | | | | | | | | | | | | | | |
| 1.16 | Conduct periodic ground visits for monitoring the implementation of | | X | X | X | | X | NR | X | T | X | NR | | | | |
| 1.17 | Support the functioning of DEP for monitoring the implementation of | | X | X | | | X | P | X | T | | | | | | |
| 1.18 | Evaluate the mid-term implementation of | | X | X | | | X | NR | X | T | | | | | | |
| 1.19 | Conduct a final evaluation of the Implementation of HSS-Global | | | X | X | X | | | X | NR | X | NR | X | NR | | |
| **Objective 2: Develop human resources for health care by the end of 2010** | | | | | | | | | | | | | | | | |
| 2.1 | Implement the plan for strengthening competencies of community players | | X | X | | | X | P | X | T | | | | | | |
| 2.2 | Recognize the best two HF, by district, based on results /year, especially in vaccine | | X | X | | | X | P | X | T | | | | | | |
| 2.3 | Train the HSPC players in health planning for better inclusion of preventive and curative activities | | X | | | | X | T | | | | | | | | |
| 2.4 | Implement an orientation plan for teachers in schools and training institutes of health staff | | X | X | | | X | NR | X | T | | | | | | |

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| 2.5 | Conduct a workshop for revising the training curriculum in schools and training institutes | | X | X | | | X | NR | X | T | | | | | | |
| 2.6 | Support the execution of an active research in EPI in 5 Districts with poor EPI indicators | | X | X | | | X | P | X | NR | | | | | | |
| **Objective 3: Strengthen social mobilization and social marketing for areas with poor utilization rates** | | | | | | | | | | | | | | | | |
| 3.1 | Contractualize social mobilization and social marketing for health with | | X | X | | | X | P | X | T | | | | | | |
| 3.2 | Conduct an annual external evaluation of performances of contracting facilities for social | | X | X | | | X | P | X | NR | | | | | | |
| 3.3 | Conduct an operational research on community based epidemiological surveillance | | X | X | | | X | P | X | T | | | | | | |
| 3.4 | Train and coach 8000 PHC workers involved in the implementation of | | X | X | | | X | P | X | T | | | | | | |
| **Objective 4: Improve the maintenance system for equipment and infrastructure by the end of 2010** | | | | | | | | | | | | | | | | |
| 4.1 | Train 300 users in the current maintenance of medico-technical | | X | X | | | X | P | X | P | | | | | | |
| 4.2 | Train 30 maintenance technicians of the cold chain | | X | | | | X | P | | | | | | | | |

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| 4.3 | Equip DGIEM with a 4x4 vehicle for the maintenance of biomedical equipment, including cold chain | | X | | | | X | T | | | | | | | | |
| 4.4 | Outsource the curative maintenance of bio-medical equipment with | | X | X | X | | X | NR | X | NR | X | T | | | | |
| 4.5 | Construct and equip 1 IEMD in the health region of Cascades[39] | | X | | X | X | X | NR | | | X | P | X | P | | |
| 4.6 | Construct and equip 3 maintenance | | X | | X | X | X | NR | | | X | P | X | P | | |
| 4.7 | Construct 3 incinerators with good quality and high-capacity in | | X | | | | X | NR | | | | | | | | |
| **Objective 5: Strengthen the basic health infrastructure and equipment in the poorly serviced areas by the end of 2010** | | | | | | | | | | | | | | | | |
| 5.1 | Construct and equip 5 HSPC in the areas with poor health | | X | | X | X | X | NR | | | X | P | X | P | X | P |
| 5.2 | Equip 4 health districts with 4 4x4 pick up vehicles for supervision | | X | | | | X | T | | | | | | | | |
| 5.3 | Equip 100 HSPC with motorcycles for | | X | | | | X | T | | | | | | | | |
| 5.4 | Equip the Health Information System of DEP with a 4x4 vehicle | | X | | | | X | T | | | | | | | | |
| 5.5 | Equip the village units of the 4 health regions with 400 bicycles for | | X | | | | X | T | | | | | | | | |

[39] Activities carried out in 2012

[40] Activities carried out in 2012

| ACTIVITIES | | FORECAST | | | | | EXECUTION | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2008 | 2009 | 2010 | 2011 | 2012 | 2009 | Level* | 2010 | Level* | 2011 | Level* | 2012 | Level* | 2013 | Level* |
| | the implementation of community activities in terms of immunization, distribution of | | | | | | | | | | | | | | | |
| 5.6 | Equip the DPI with a 15-ton truck for supplying the regional depots | | X | | | | X | T | | | | | | | | |
| 5.7 | Equip 3 CMA with ambulances for references and health evacuations | | X | | | | X | T | | | | | | | | |
| 5.8 | Construct and equip 2 EPI depots in 2 of the 8 newly created HD (Mani | | X | | X | | X | NR | | | | | | | | |

[41] Activities carried out in 2012

## 5.5. MONITORING THE INDICATORS APPEARING IN THE ANNUAL PROGRESS REPORT 2013

Below (table 9) are the degrees of achievement of GAVI HSS objectives as estimated by the Government of Burkina Faso at the end of the year 2012. This table is an excerpt from the annual progress report 2013. The approach of quantification using percentages on outputs can be used for monitoring. The process analysis carried out under this evaluation will come later. It focuses on examining the level of achievement of objects (outcomes) by a systematic analysis of the accuracy of the implementation.

**Table 9: Progress on targets achieved**

| Objectives | Baseline | | Request objectiv | 2009 | 2010 | 2011 | 2012 | Sources/ Observations |
|---|---|---|---|---|---|---|---|---|
| | Ref. Value | Source | | | | | | |
| **Objective 1: Improve the organization and management of health services by 2010** | | | | | | | | |
| **1.1 National Coverage by DTP– HepB-Hib 3** | 95.31 % | Statistical Yearbook, | 100 % | 103 % | 103.4 % | 104 % | 102.9% | Statistical Yearbook |
| **1.2 Number of districts achieving ≥80% of coverage by DTP– HepB-Hib 3** | 52 | Statistical Yearbook, | 100 % | 63 | 63 | 62 | 63 | Statistical Yearbook |
| **1.3 Mortality Rate for children less than five years of age (for 1,000)** | 184 | DHS 2003 | 184 | 184 | 184 | 129 | | DHSIV 2010 |
| **1.4 Coverage rate for PNC2** | 61.2 % | Statistical Yearbook, | 76 % | 78 % | 72.8 % | 74.4 % | 75.6% | Statistical Yearbook |
| **1.5 Rate of assisted childbirth by qualified staff** | 42.9 % | Statistical Yearbook, | 64 % | 77.30 % | 75.1% | 78.3 % | 82.1% | Statistical Yearbook |
| **1.6 TT2+Coverage in Pregnant women** | 81.41 % | Statistical Yearbook, | 90 % | 93 % | 96.29 % | 90.9 % | 92.7% | Statistical |
| **1.7. % of Health Districts benefiting from a LQAS evaluation** | 15 % | DPI 1994 | 20 % | 71 % | 100 % | 100% | 100% | |
| **1.8. Ratio of functional pilot sites offering local maternal and child health care services** | 0 % | DSP 2007 | 20 % | 0 % | 0 % | 0 % | | |

| Objectives | Baseline | | Request objecti | 2009 | 2010 | 2011 | 2012 | Sources/ Observations |
|---|---|---|---|---|---|---|---|---|
| | Ref. Value | Source | | | | | | |
| | | | | | | | | |
| **Objective 2: Develop human resources in health sector by 2010** | | | | | | | | |
| **2.1. Ratio of HSPC having a plan of action for quality** | 50 % | HD 2007 | 100 % | 100 % | 100 % | 100 % | | |
| **Objective 4: Improve the maintenance system of equipment and infrastructures by 2010** | | | | | | | | |
| **4.1. % of maintenance workshops constructed** | 15.8 % | DSP 2007 | 50 % | 75 % | | | | |
| **Objective 5: strengthen the basic health infrastructures and equipment in poorly served areas by 2010** | | | | | | | | |
| **5.1. % of HSPC constructed and equipped.** | 85.8 % | DSP 2006 | 90 % | 90 % | | | | |
| **5.2. % of CMAs provided with an ambulance** | 88.8% | DGIEM 2007 | 95 % | 96 % | | | | |

Sources: MOH: Annual progress report 2013 presented by the Government of Burkina Faso, completed for 2012 with AS2012 data,

# SECTION 6 | HSS RESULTS

## 6.1 TERMS

After revising the evaluation terms, the analysis of effects and impacts of GAVI HSS intervention focuses on:

i) evaluating the evolution of changes in vaccine activity in the case-districts;
ii) identifying possible "strong" results emerging from site visits, especially with respect to contextual factors that could explain the degree of achievement of results;
iii) identifying national key issues to be considered in the deployment of the next GAVI HSS intervention.

Questions related to the efficiency were addressed in the next section on the process analysis.

## 6.2 PRELIMINARY CONSIDERATIONS

As we have seen above, GAVI HSS covers a range of activities that must all meet systematic requirements, known as bottlenecks.The latter are mostly circumstantial, in the aim that a wide range of actions should be considered, targeting both: (i) direct services and support functions (maintenance, management, monitoring, operational research); (ii) national level, intermediate level (regions - districts), and service points (HSPC) and communities targeted due to their low coverage or recent creation. Some of these activities are generic, mainly benefiting the health system and basic health care activities "in general". Others are specific, i.e. especially benefitting the immunization activities.

The intervention addresses both the provision of inputs and the revision of processes. However, a wide range of devices can be envisaged to strengthen the health system for the purpose of reducing health needs and improving coverage. Inevitably, selections were made due to resource constraints, specific context of preferences of its designers, and trade-offs requiring strategic planning.

Consequently, GAVI HSS meets the situational needs. Furthermore, the intervention may not cover all the action mechanisms that could improve vaccine coverage. In fact, it emphasizes more on structural elements: strengthening competencies in organization and management of healthcare services, construction and equipment of centres, acquisition of logistics, good functioning of equipment and logistics, awareness-raising of people and strengthening newly created districts. It poorly addresses systemic and organizational challenges (i.e.: efficiency of the regulation, articulation of service levels, leadership, other than financial motivation of workers, professional practices, efficiency of production) identified by certain independent reviews[42].

The analysis of GAVI HSS impacts should be considered within the framework of this specific reality and should consider the restrictions it imposes on the chain of acknowledged results. If outputs are measurable (see section 5 on process analysis), centring the bottlenecks and scattering of activities restricts the potential of measurable effects on the health system (organization, efficiency, effectiveness), the performance of the sub-sector of immunization, or the survival of target populations. Hence, the links between outputs, effects and impacts are due to the nature of intervention, too bound to inform robust change theory for evaluation purposes.

Failing to provide evidence on the effects and impacts of the program, this analysis is based on

the following elements:

1) The perception of stakeholders on the value addition of GAVI HSS.
2) A review on the evolution of vaccine coverage in target districts through

intervention. The results on resource utilization are given in section 5.3

## 6.3 VALUE ADDITION OF GAVI HSS

An evaluation questionnaire was submitted to seven key players involved in the design or implementation of GAVI-HSS. A limited response rate leads us to interpret the results with caution and does not allow drawing definite lessons. Nevertheless, we do not accept liability of the following:

- Stakeholders agree to recognize a value addition in HSS. GAVI HSS helped resolve the bottlenecks to limit the efficiency of immunization interventions and thus responded to its first mission;
- GAVI HSS value addition mainly lies in its ability to complement the resources provided by the State. GAVI HSS provided "a little oxygen" to overcome the existing difficulties. The financing for constructions and acquisition of rolling means are illustrations that are spontaneously and commonly cited examples;
- Opinions are divided about of GAVI HSS's ability to improve the visibility of immunization to the Ministry of Health or decentralized bodies;
- Bottlenecks affecting the immunization are several and GAVI HSS cannot, obviously, meet all the requirements;
- Few stakeholders estimate that HSS contributed to the improvement of vaccine coverage.

There is no consensus in assessing the level of the health pyramid that most benefited from these contributions. Few respondents estimate that the districts targeted by HSS are those that withdrew the most tangible benefits. Others estimate that these benefits are distributed among the central level, health regions and districts.

The interviews conducted on the site suggest that it was in the periphery that the GAVI HSS value addition is the most tangible:

- Although the construction of health centres is still not complete, these subsidies contribute to the increase in the supply of services and health coverage;
- Since it strengthens the functioning of districts and supplies regional and district depots with vaccines and consumables, the acquisition of rolling stock is considered beneficial. *"This is not to compliment them (GAVI HSS); at present, it is the only vehicle which saves us (4x4 vehicle acquired by GAVI HSS); it's our only supervision vehicle that runs; we had another vehicle which is ruined. Our only supervision vehicle runs since then; this is what saves us".* On the contrary, a district manager that did not receive the vehicle from GAVI HSS said "*all our vehicles are under repair; for some activities I should arrange with the High-Commissioner of the province".*

[42] Bicaba A, Haddad S, Kabore M, etc. Monitoring the performance of the Expanded Program on Immunization: the case of Burkina Faso. BMC International Health and Human Rights. 2009; 9(Suppl. 1):S12. Haddad S, Nougtara A, Fournier P. Learning from health system reforms: lessons from Burkina Faso. Troop Med & Into Health. 2006; 11(12):1889–1897. doi: 10.1111/j.1365-3156.2006.01748.x. Haddad S, Bicaba A, Feletto M, etc. System-level determinants of immunization coverage disparities among health districts in Burkina Faso: a multiple case study. BMC International Health and Human Rights. 2009; 9 (Suppl. 1):S15.

- Rewarding the performing HSPC is seen as a source of emulation. According to a district official: *"reward the best HSPC, it's a good thing for the health districts, as the non-rewarded HSPC will increase their efforts in the following years to obtain this recognition"* according to a member of DMT.

On the contrary, with these advantages perceived by GAVI HSS, players at the peripheral level are dissatisfied because of the lack of flexibility of programming which does not help them target their specific needs: *"you should give us the outline and areas concerned, and leave us the flexibility to target activities according to our needs of the moment, instead of sending us funds with fixed activities that we cannot change, if there was this flexibility, we could add the repair of our refrigerators to these activities"* (health district management team). Hence, overall, the GAVI HSS stakeholders have a favourable evaluation.

## 6.4 CHANGES IN IMMUNIZATION COVERAGE

This is more of a change analysis than an effect study. The analysis mainly aims at examining the evolution of immunization activities for each of the antigens during the observation window 2006-2012 in each district case.

The data given in the table and the figures was provided by national health statistics. During the previous works we showed that these statistics, although imperfect, could be profitably used for longitudinal analysis, provided that the indicators used are not too distorted by the inappropriate population denominators. Public statistics on the target population size and evolutions are not adequately valid to be prepared for statistical analysis for evaluation purposes. Hence, in the next section, we will use the activity indicators (monthly immunizations carried out for each antigen) rather than coverage measures. The evolution of each case-district is viewed with the median of other districts of the country (after excluding statistics of two metropolitan regions, Ougadougou and Bobo-Dioulasso). This set can be seen as the district that is not involved by the local activities related to GAVI HSS

The statistics are presented on the following vaccines: BCG reflecting the first contact with immunization department and in some way, the demand for immunization, three doses of OPV, DTP+HepB-Hib and MV which further increases the loyalty of patients to immunization services. As shown in table 10 below, the vaccine activity experienced an increase in Burkina Faso during the observation window examined and this increase concerns the districts in the case study. This also relates to the recently created districts of Karangasso-Vigue and Mangodara.

**Table 10: Number of children immunized at the beginning of the period and end of the period for each of the case-districts based on the median of the rest of the country.**

| | BCG | | OPV | | DTP | | Measles vaccine | |
|---|---|---|---|---|---|---|---|---|
| **District** | **Jan-06** | **Dec-12** | **Jan-06** | **Dec-12** | **Jan-06** | **Dec-12** | **Jan-06** | **Dec-12** |
| SAPOUY | 638 | 824 | 585 | 806 | 488 | 806 | 634 | 678 |
| GAYÉRI | 232 | 406 | 103 | 413 | 127 | 1155 | 147 | 397 |
| DÉDOUGOU | 1221 | 1313 | 946 | 1155 | 1000 | 1155 | 1066 | 1244 |
| SOLENZO | 985 | 1362 | 970 | 1103 | 814 | 1103 | 989 | 1136 |
| Country median | **815** | **897** | **688** | **803** | **630** | **803** | **689** | **781** |

| District | Jan-08 | Dec-12 | Jan-08 | Dec-12 | Jan-08 | Dec-12 | Jan-08 | Dec-12 |
|---|---|---|---|---|---|---|---|---|
| KARANGASSO | 458 | 504 | 366 | 483 | 369 | 483 | 378 | 458 |
| MANGODARA | 773 | 834 | 614 | 936 | 614 | 936 | 701 | 788 |

When collected on a sufficiently large period, the longitudinal series on activity measurements are suitable for two types of evaluation: i) a visual analysis of the evolution and accidents occurring at particular periods (for example, before or after GAVI HSS implementation); ii) statistical analysis by interrupted series[43]. The following developments belong to the first type of analysis and focus on the monthly evolution of the number of immunized children. To ensure the comparability of data between districts of different sizes, the series were entered in 100 in January 2006. To reduce the magnitude of accidents in the series, the data were smoothened by rolling average of 3. HD of Gayeri whose development is unusual is dealt with separately.

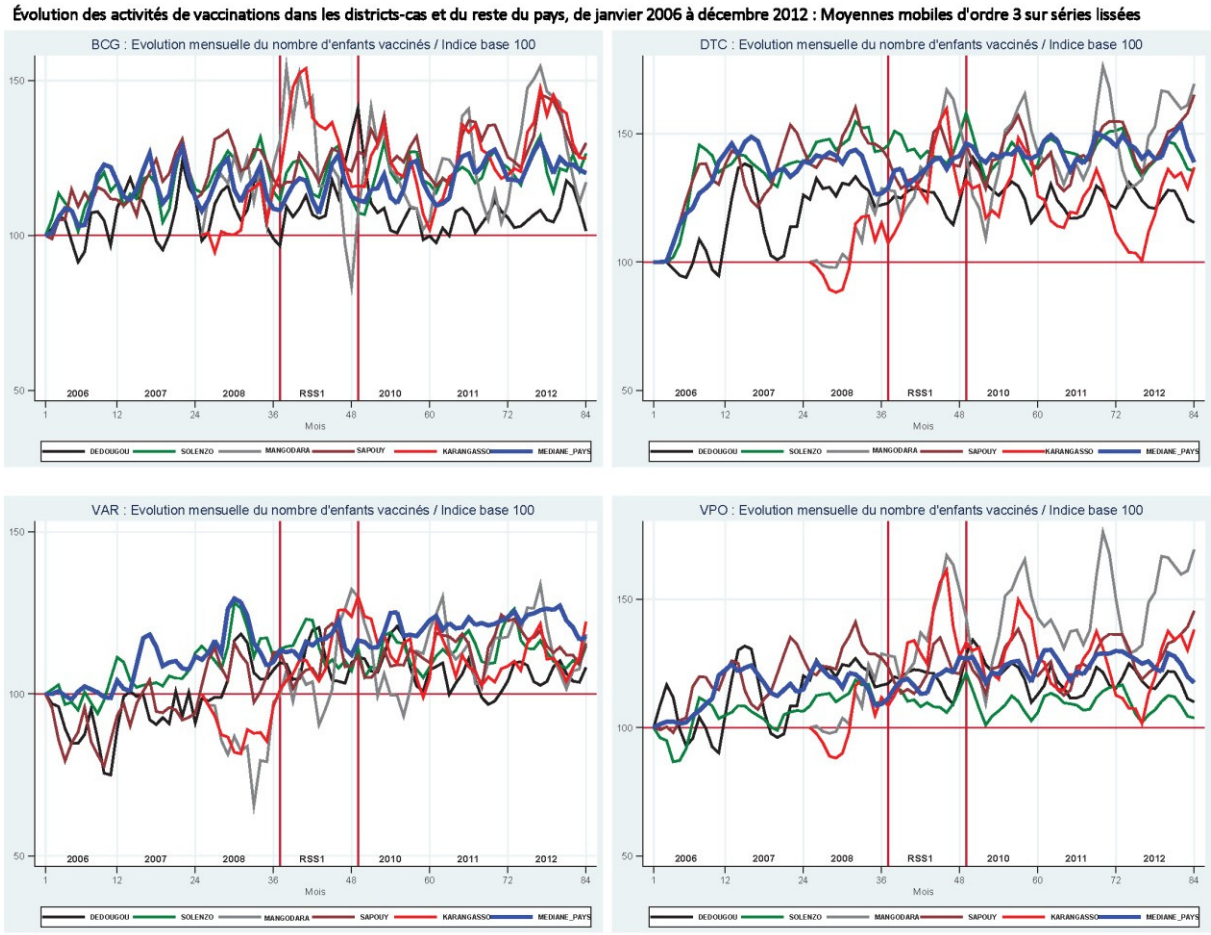
Unsurprisingly, the visual evaluation states that:

- a secular upward trend that spots seasonal accidents. This trend observed on an observation window of 12 years reports the progress made. It is attributable to a set of systems and actions conducted by the national authorities and their partners;
- the absence of singular trend in case districts, compared to district blocks not covered by local interventions of GAVI HSS. Their trajectories are broadly comparable to other districts;
- no clean break (jump intercept) in the series of case districts in the months or years after the implementation of GAVI HSS
- absence of distinctive modification of trajectories (slopes) observed in the case districts after the implementation of GAVI HSS intervention. In other words, in the circumstances, we can identify the presence of a measurable effect on immunization.

[43]These mixed models identify the jumps and slope changes in the evolution of a series, by trying to attribute these changes to the deployment of an intervention (or withdrawal). These models can also explore variations observed in the response of health centres to the deployment of interventions and report any heterogeneity of effects.

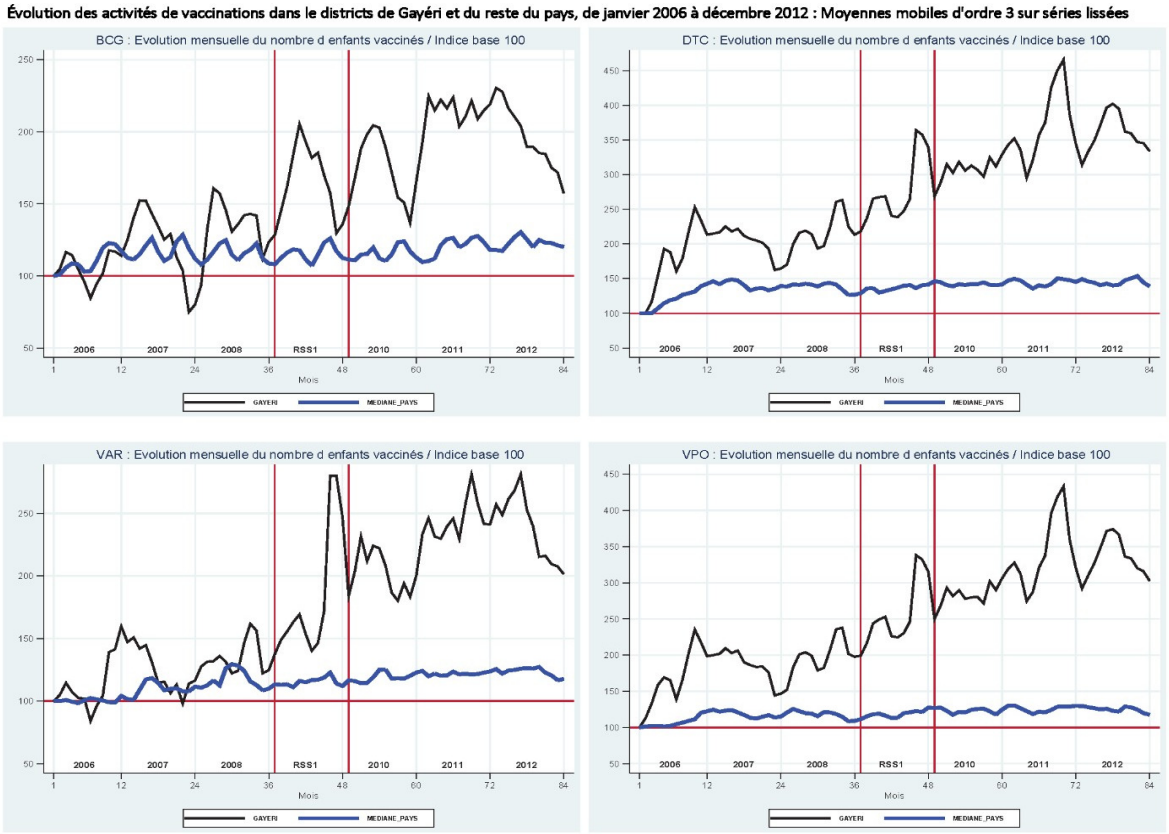
**Figure 6 :** Evolution of immunization activities in the case districts from January 2006 to December 2012

**Figure 7 : Evolution of immunization activities in case districts: smoothed series**




The district of Gayeri is a specific case. There was a significant growth in the activity, even before the introduction of GAVI HSS. According to our information, this progress is due to the implementation of several initiatives targeting women and children, especially free health care for these two groups and implementation of the "FASO PROGRAM" project by "Hellen Keller International" also targeting women and children less than two years.

**Figure 8 : Evolution of the activity in the district of Gayeri**




*i) the results of the evaluation of the evolution of the activity in the case districts do not mean that GAVI HSS had no positive outcome in the concerned districts. The stakeholders appreciate the actions conducted. But they do not cause measurable changes in immunization coverage, as anticipated in the evaluation study and review of the intervention theory.*

*ii) It is not excluded that the intense health services strengthening strategy, targeted on immunization, less fragmented, implemented faithfully and completed over a wide time window, may result in measurable short-term effects (intercept jump) or medium to long term effects (modification of trajectories);*

*iii) In the circumstances, the modest potential theoretical effects eliminate the need for statistical investigations driven by the search of a significant effect of the introduction of GAVI HSS. These impact models may be relevant if the expected impacts of GAVI HSS2 were more tangible.*

# SECTION 7 | LESSONS LEARNED AND RECOMMENDATIONS

i) What are the important lessons that can be drawn to facilitate an improved design and implementation of HSS program in the future, in Burkina Faso and other countries?

Reflecting on the lessons learned starts with the team's response to the following question raised by GAVI Secretariat after submitting the aide-mémoire: "Were conditions for the success of GAVI-HSS created at the time of its launch?".

## 7.1 WERE ALL CONDITIONS FOR THE SUCCESS OF GAVI-HSS CREATED AT THE TIME OF ITS LAUNCH?

*Preliminary remark: this tool was developed by the evaluation team; scores were attributed by the four members of the evaluation team using internal voting procedure which was followed by deliberation and led to a consensus rating.*

| Area of consideration | Criteria | Overall evaluation | Score |
|---|---|---|---|
| **Application** | 1. Stakeholders have a clear understanding of the expectations of partner organizations and the logic of intervention.<br>2. "Schedules" of the national party and the partner are reasonably convergent.<br>3. The content of the application reflects the vision of the promoters (GAVI Alliance). | The "GAVI-HSS" concept which links health system strengthening, removal of bottlenecks, improvement in vaccine coverage and other interventions in maternal and child health is relatively complex in nature. It could be a source of ambiguity for some stakeholders of the national party.<br>The application reflects the vision of GAVI and was drafted keeping in mind the instructions set. Bottlenecks and systemic needs seem to have been well understood and correspond to real needs. The program thus comes under the logic of a response to unmet needs. But, it has led to a fragmented approach. Absence of an explicit reference to immunization has led to dispersions.<br>Changing the application format during the process of | 70% |
| **Shared vision within the national party** | 4. There is a reasonable consensus within the national party on the vision about the purpose of intervention.<br>5. The process of preparation is participatory. There is general consensus on areas of intervention, scope of intervention (centre – periphery) and its program.. | There is consensus on the health system, but there is difference of opinion on identification of some interventions due to the multiplicity and specificity of needs of the stakeholders concerned.<br>Ambiguity around the nature of concretization of the GAVI-HSS concept – financial mechanism vs. intervention project – hampers readability of the intervention and its accountability.<br>Shared responsibility in GAVI-HSS implementation and absence of a GAVI-HSS "Coordinator" further reduced readability of the intervention and hampered the emergence of an unequivocal vision for it.<br>The process of identifying the content of the intervention was participatory, but the peripheral level had little involvement in it. | 70% |

| Area of consideration | Criteria | Overall evaluation | Score |
|---|---|---|---|
| **Appropriate anchoring** | 6. The intervention is aligned with the priorities of national health policies.<br>7. The organizational positioning of the intervention is readable, responsibilities have been defined, the institutional model encourages an efficient and responsive leadership and management, coordination and quick decision-making.<br>8. There is seamless and natural coordination among the departments responsible for immunization activities.<br>9. There is efficient coordination between the management's technical functions and | The intervention is aligned with the national policies.<br>Institutional anchoring was inadequate. Organizational positioning was neither sufficiently readable nor appropriate for an effective leadership, emergence of efficient coordination or quick decision-making. Co-responsibility defined for implementation, inadequacy in the definition of responsibilities and tasks of the DSP, and difficulties in interdepartmental and inter-program collaboration led to difficulties in implementation.<br>Mechanisms of coordination and interaction with the Directorate of Prevention through Immunization were inadequate. Although coordination, monitoring and control of GAVI-HSS implementation were in principle the responsibility of NHDP, the HDSP i.e. the fund managers in fact, played a leading role. | 30% |
| **Implementation team** | 10. Responsibilities are clearly defined by the national party. The team has the required mandate to carry out its coordination function.<br>11. The intervention is led by a motivated and reputed team, representative of the key components.<br>12. Skills required for implementing, steering and coordinating activities in the areas of intervention and for the purpose of monitoring are available.<br>13. The team is led by a leader who is available, reputed, and equipped with the necessary mandate for proper execution of strategic and operational management functions, interface management with the steering committees, financial management organizations, and the external partner (GAVI).<br>14. Stability in the team and the reporting system will help preserve institutional memory and ensure efficient monitoring. | The intervention was not placed under the direct responsibility of a department or a team. It suffered due to a not-so-clear definition of roles. The formal appointment of a team with a mandate to execute the project is more important than the hierarchical administrative structure that neither encourages autonomy nor taking initiative. Changes in the organizational structure could not be foreseen. In such a situation, they could greatly affect management and implementation capabilities.<br><br>Skills were available but were not necessarily mobilized. Competent resources were available with difficulty on an ad hoc basis given the high number of requests, changing priorities and uncontrolled schedules.<br><br>The focal point responsible for the leadership was not formally appointed before the implementation. An expert from the Ministry acted as an interim focal point. The intervention however, greatly benefitted from his high degree of motivation. The stability and commitment of the interim focal point helped compensate for the absence of a coordination unit the mobility of people observed in other places. | 50% |

| Area of consideration | Criteria | Overall evaluation | Score |
|---|---|---|---|
| **Resources** | 15. Resources required are clearly identified.<br>16. Resources available can be planned for and deployed on time as per the process defined beforehand and accepted by the parties.<br>17. Resources are sustainable. | Resources, particularly financial resources, are clearly identified. GAVI-HSS's financial assistance can be planned for three years of implementation and made available in advance. The arrangement allows carrying forward of unused funds from one year to another. The national party could immediately make use of the HDSP financial management system accepted by all stakeholders and technical and financial partners. Funding is not sustainable; this arrangement is clearly defined right from the start. "Countries must reflect on the financial and technical sustainability of GAVI support to HSS and explain how they intend to support recurring costs and maintain the effects of GAVI on HSS beyond the duration of GAVI funding…"[24] | 80% |
| **Preparing for implementation** | 18. The program is realistic. It takes capabilities and local constraints into account.<br>19. Risks and difficulties (critical conditions) have been anticipated; special attention will be paid to implementation of the activities described.<br>20. Timelines are realistic, efforts are divided harmoniously, critical tasks or those with a poor margin are identified.<br>21. Modalities defining possible adjustments in the activity program and resource utilization are brought to the notice of stakeholders at the peripheral level. | The program was relatively realistic for activities at the peripheral level, because they were anchored in the district action plans right from the start. It was not as realistic for activities at the central level. It was not at all realistic for the costly construction activities. Inherent difficulties and constraints for this type of activities had not been adequately anticipated.<br>The planning process relies a priori on the activity program. This technocratic approach is not appropriate in a situation where there are multiple sources of uncertainties and several parameters are outside the control of the implementation team. A more adaptive approach has a much higher potential for success, avoids repeated adjustment in the program, and repeated cycles of justifying and getting approval. The best is an enemy of the worst and a multi-year micro-planning logic results in significant transaction costs for the national party and its partner.<br>Modalities defining potential rescheduling are not known, particularly at the peripheral level, and this has possibly increased their rigidity perception of the intervention. | 50% |
| **FINAL SCORE (maximum %)** | | | **58%** |

[24] GAVI Alliance, *ibid.* p 7

## 7.2 LESSONS LEARNED FROM PREPARING AND IMPLEMENTING GAVI-HSS1

For understandable reasons, some broad lessons have already been highlighted in the evaluation given in the preceding section about the capability of project promoters to create preliminary conditions for implementation.

### 7.2.1 Lessons from preparation of the GAVI-HSS application

1. The Ministry of Health was able to create an "atypical" program with an unusual format, involving several Government directorates and programs, although initial involvement of stakeholders from the peripheral level would have been more significant.

2. The program is aligned with the national health policy. Activities conducted at the peripheral level largely fall under the district action plan. This high level of integration was decisive; it encouraged a good level of accuracy in implementation of activities at the peripheral level.

3. Targeting bottlenecks and systemic needs is convincing; it corresponds to real needs and continues to remain a part of instructions formulated by the GAVI Alliance partner.

4. Efforts to identify (application) bottlenecks in the health system concerning a classically vertical program (immunization) and even the deliberation process involved throughout the current evaluation proved an opportunity to strengthen the debate within MOH on the concept of HSS, a theoretically well-known concept but with little operationalization. Implementation of GAVI-HSS2, which was largely inspired by the limitations observed in this aspect, will definitely constitute progress made in the general problems faced in operationalizing the HSS concept in Burkina Faso.

5. With GAVI's preference, the intervention was not positioned as an autonomous project. Its financial management was under HDSP and its technical coordination and use of health information system was under the Directorate of Studies and Planning. This model boasts the dual advantage of maintaining a light structure, thus avoiding the setting up of a dedicated management unit and structuring the intervention around the main functional linkages maintained with the technical and financial departments. However, the model was not apt in the specific organizational context, whether related to readability of the intervention or to effectiveness of the management and reasoning.

6. Room for flexibility in the choice of areas of intervention and a relatively limited interface with the departments in charge of immunization led program promoters to fulfil pressing needs – whether or not tangibly – related to immunization.

7. As a corollary, there was also a tendency to consider and use the program as a complement to the resources meant to respond to the unsatisfied needs and to support the activities planned earlier, whether these needs were related to immunization or not.

8. The will to cover different levels of the health pyramid around five distinct areas of intervention created a dissipating effect. The division of resources was not good for the readability of the intervention and reduced its potential effect.

9. Persistent bottlenecks in immunization were not sufficiently targeted by the intervention, especially, the condition of community health workers, cold chain and transport logistics.

### 7.2.2 Lessons from institutional anchoring and the kind of GAVI-HSS steering

10. Unclear institutional anchoring proved unfavourable to effective leadership and sufficient readability of the intervention. Absence of an unequivocal and recognized decision-making centre within the Ministry was felt during implementation and monitoring-evaluation of the intervention and this did not encourage effective management and real time responsiveness to difficulties in implementation.

11. Coordination mechanisms were not sufficiently formalized, before or while introducing the intervention. Their performance also suffered from the absence of an unequivocal responsibility. Consequences were mainly felt on reliability of the implementation in case of complex activities (construction) and those concerning the central level.

12. The extremely limited presence of the Directorate of Prevention through Immunization in monitoring the program conveyed an image of dissociation among the health system strengthening activities and activities for improving vaccine coverage.

13. The human dimension proved key in the observations made during GAVI-HSS implementation in Burkina Faso. In fact, the focal point was proof of great motivation even while this post was not formalized, and stakeholders at the peripheral level were efficient despite difficult working conditions.

### 7.2.3 Lessons from implementation

Accuracy in implementation

14. Accuracy in implementation at local level – region and district – is satisfactory: a large majority of activities conducted fall under the annual routine district program. Such integration encouraged a high degree of completeness and limited the risks of delay. The only shortfall in implementation at this level was regarding the “search” activities.

15. Activities that were delayed, not completed or not executed mainly concerned the central level. Two activity groups particularly lacked completion: (1) monitoring of intervention and (2) construction and equipment which prove to be most costly. Stakeholders involved in monitoring GAVI-HSS (DGSSS, HDSP, NHDP monitoring committee, HDSP steering committee, etc.) did not have an adequately coordinated reaction or even an adequate reaction to the extremely partial execution of construction activities during the implementation period of the intervention.

16. Although they only represent a limited part of the number of activities carried out, building and equipping centres constitutes by far the most central expense item in intervention. It involves important outcomes requiring a coordinated and farsighted management, adequate expertise in construction management, and meticulous monitoring. These conditions were not created.

17. For these activities, mechanisms of information, warning, communication, coordination and collaboration among different involved departments and programs of the MOH did not function effectively.

18. Annual reports clearly mentioned difficulties in implementation. Yet, reporting timelines were not favourable for quick and efficient decision-making. GAVI steered various actions in the Ministry's departments to respond to the shortfall in implementation and poor resource utilization rates reported.

### Organization, management and monitoring of activities

19. The informal mechanism helped ensure successful execution and acceptable monitoring of tasks at peripheral level and activities requiring minimal management. Yet this mechanism proved ineffective in managing more complex and costly activities.
20. Shortfalls in implementation mostly stem from the absence of leadership by a management and coordination unit equipped with a formal mandate and responsible and accountable for implementing actions and managing interface with the peripheral level, central departments of the Ministry, steering committee and the partnership (GAVI Alliance).
21. The central level gave priority to its existing monitoring system to monitor intervention: HSPC monthly reports, HD and RDH quarterly reports, HDSP half-yearly progress reports, and sessions on funding and adopting district action plans.
22. With the current reporting system, stakeholders involved in decision-making (HDSP, DGSSS, GAVI) are informed of progress in GAVI-HSS implementation with a time lag of several months, sometimes even a year, which is unfavourable for effective decision-making and avoiding loss of resources.

### Resource utilization

23. Generally speaking, deadlines assigned to resource utilization in health districts were respected.
24. In reality, the overall poor utilization rate observed results from the extremely low utilization rate in a small group of activities that are also the costlier.
25. Poor resource utilization rate in construction-related areas of intervention results from inadequate management. The Ministry of Health has experienced staff in this subject and can be employed in this kind of activities.

### GAVI and other TFP participation

26. GAVI's involvement in monitoring the progress of intervention fulfilled its mandate and its philosophy to provide support and assistance to the beneficiaries.
27. Five GAVI missions were carried out during the term of the intervention. The GAVI-HSS component appears to have been raised in most of the interactions among the national party and members of the missions. Several emails testify to the concerns of the GAVI Secretariat as to the implementation of activities and delays encountered in fund utilization.
28. The APR-based monitoring system provides a fairly enlightening annual summary regarding progress in activities. Deadlines for preparing and sending these reports however do not help in quick decision-making in case of problems. More flexible and regular communication methods could prove a better interface between the national party and the organization.
29. Partners participated in the formal process, which gave GAVI-HSS monitoring and approval of annual reports and its pattern, year after year. However, there are no factual details demonstrating their concrete or active involvement in implementing activities related to areas of intervention, nor in supporting intervention management.

Results

30. Burkina Faso shows a secular rising trend in the number of immunized children. This trend takes countrywide progress into account. In all probability, this is attributable to the entirety of mechanisms and actions led by the national authorities; actions which are neither identified nor made conspicuous in the purview of this investigation.
31. Activity progress in specimen districts, which have benefited from direct support from GAVI-HSS is comparable to that in other districts.
32. We do not see any change in the trajectories (inclinations) observed in the specimen districts after implementation of intervention. In other words, we cannot bring out the presence of a measurable effect on immunization.
33. GAVI-HSS chosen indicators cannot account for the effectiveness of intervention. The infant and child mortality indicator is not appropriate in the given circumstances. Indicators added by the Ministry of Health are in accordance with the main objectives mentioned in the application, but they are less informative. None of them are related to the health of the child and they are insufficient in their specificity and sensitivity to change.
34. It is possible that an intense HSS strategy focused on immunization and actively implemented and executed over a longer period of time could show measurable results in short, medium and long-term vaccine coverage.

A well-known situation

35. A review of the evaluation reports commissioned by GAVI and related to HSS shows that in many ways, the situation encountered in Burkina Faso can be compared to that in other countries. Let us note for example:
    i. Inadequate attention paid to monitoring and evaluation of GAVI-HSS intervention;
    ii. Mismatch between reporting systems of HDSP (quarterly report) and GAVI (annual report);
    iii. Gap between the year in which the funds were received and the time when implementation started;
    iv. Late receipt of the first instalment of funds intended for implementing the intervention.

#### 7.2.4 Related to some specific activities

36. Inadequate understanding of the complexity of some activities led to failures in implementation, as seen in all construction-equipment activities planned.
37. Intervention choices must be “feasible”. A reasonable risk-evaluation must be carried out. Maintenance is one such example.
38. The choice of some *a priori* relevant interventions such as mobilization and social marketing in areas with poor service utilization rate proved irrelevant due to the contracting procedure, which is a fundamental strategy for these interventions but that does not target immunization activities.
39. The DQS support opportunity by GAVI-HSS does not have a consensus; it must be explicitly reviewed.

## 7.3 RECOMMENDATIONS

### 7.3.1 Encourage a common GAVI-HSS vision

For GAVI

1. Clarify the GAVI concept of “HSS-immunization” to national partners.
2. Eliminate any ambiguity in the nature of HSS intervention and position it clearly as an “intervention built on the enumerated action strategies” or as “a financial mechanism meant to fulfil the unsatisfied needs”.
3. Adapt forms and other documents provided to the Ministry of Health for preparing its application or for monitoring the implementation of the project, according to the chosen positioning.
4. Limit the changes in forms to be filled by the national party.

For GAVI and the Ministry of Health

5. Promote the emergence of a common vision of what health system strengthening means in relation to immunization.

Note: The second application was clearly based on lessons learned from GAVI-HSS1, particularly with respect to the indispensable connection between HSS and immunization. There seems to be a common vision about the nature of bottlenecks in the health system that must be addressed to improve immunization.

This link might eventually help add value to the lessons learned in health system strengthening and thus benefit the vertical programs like immunization. The Ministry of Health could capitalize on lessons learned from the various HSS projects promoted by the partners.

For the Ministry of Health

6. Follow the policy of aligning areas of intervention with national policies and anchor action plans for the peripheral level.
7. Create conditions required for promoting an understanding that is common to “HSS-immunization” and the stakeholders’ support.
8. Promote a participatory systematic approach in all stages of design and implementation of the intervention, involving the centre and the peripheral level.
9. Ensure a coherent, unequivocal and readable institutional positioning of the intervention encouraging recognition by all directorates and departments, an efficient leadership and management, coordination between different ministerial entities and an effective decision-making.

### 7.3.2 Review the planning approach (impact, participation of the peripheral level, dissociation program – vision)

For GAVI and the Ministry of Health

10. Substitute the current micro-planning by a more flexible and adaptive approach based on:
    i. A triennial planning focused on defining guidelines and global intervention strategies (strategic and tactical scope of planning);
    ii. An annual program based on a participatory approach fed by a process of continuous activity implementation monitoring on one hand, and mapping and prioritization of emerging needs on the other;
    iii. A more marked anchoring of the program in the health districts planning framework and guidelines (operational scope of planning).
11. Review expectations of the parties relative to monitoring whilst considering the inherent opportunities and constraints of the health information system.
12. Select a set of relevant performance indicators which are sensitive to change and adequately specific, rather than the indicators for the production of outputs.

For the Ministry of Health

13. Create a needs analysis process based on a systematic process of identifying current or anticipated bottlenecks, difficulties or shortfalls particularly related to immunization.
14. Follow a participatory approach in planning by involving peripheral stakeholders in the process of monitoring, mapping and prioritizing emerging needs, in a more tangible and structured manner.

For GAVI

15. Adapt planning forms to the flexible and adaptive approach suggested in the previous recommendations.

### 7.3.3 Ensure a tangible and more visible link with immunization activities

For GAVI

16. Inform bidders on the importance of tangibility of the link between HSS and immunization and include its evaluation in analysing the application.
17. Develop tools, situational simulations or illustrations to facilitate identification and selection of interventions falling within the logic of a strengthening of the health system focused on promoting immunization. Support the development of local skills as per requirement.

For GAVI and the Ministry of Health

18. Make sure that the key constituents of the Ministry involved in organizing or providing immunization services (DGH, DPI, DGSSS and Directorate of Health Promotion (DHP)) contribute effectively and collectively to the process of needs identification, application preparation, and strategic-tactical and operational planning.

19. Conduct a collective exercise aimed at observing the necessity (and in which case, how) to improve the current application (second phase of GAVI-HSS) for its improved anchoring in immunization activities and see that the needs intervention analysis is in sync with that of the concerned departments.

20. Appeal to national decision-makers and TFP to give more importance to maintaining the health system particularly the immunization system.

For the Ministry of Health

21. Target the HSS-immunization action levers in a better way with the help of an approach to identify the unmet needs.

22. Closely analyse logistics needs in immunization activities and anticipate future needs.

23. Strengthen anchoring and exploring of action strategies that will help use immunization as a much stronger lever in the Ministry's community strategies.

24. Conduct a dialogue to clarify ministerial responsibilities and modalities in DQS implementation and funding and consequently decide whether GAVI-HSS should continue to support this activity.

#### 7.3.4 Improve anchoring as well as monitoring and coordination capability of the Ministry of Health

For the Ministry of Health

25. Define and analyse different anchoring options possible for GAVI-HSS within the mechanisms of the Ministry of Health.

26. Review GAVI-HSS stakeholders' roles and responsibilities (NHDP monitoring committee, HDSP steering committee, DGSSS, HDSP, DPI, DRH, DMT, TFP, etc.) to improve program readability and distinguish mandates in a precise manner for each of the following key functions: (i) overall planning and management of interface with GAVI; (ii) monitoring activities at the central, regional and provincial levels, including monitoring disruption of priority actions to be taken; (iii) delegation (if required) for the execution of certain activities in authorized structures.

27. Produce unequivocal responsibility matrices considering division of mandates and accountability of parties.

28. Make use of this review to further involve the Directorate of Prevention through Immunization (DPI) in steering and monitoring GAVI-HSS.

29. Set up a GAVI-HSS "Management Cell" or "Technical committee for monitoring" encompassing all expertise required for monitoring the implementation, coordination and steering of annual micro planning (mapping and prioritizing emerging needs, identifying bottlenecks and current or anticipated difficulties and/or shortfalls particularly

related to immunization, periodic program reviews, interface with partners, and other mechanisms in the ministry and districts).

For GAVI and the Ministry of Health

30. For want of modifying the current reporting system, set up other mechanisms to improve dissemination of information about important aspects of implementation and to promote quick decision-making.

#### 7.3.5 Strengthen and structure consultations between GAVI / other TFP and the Ministry of Health

For GAVI

31. Ensure harmonious links among different GAVI programs in Burkina Faso. Eventually, plan for them all to report to the same steering committee.

32. Promote a higher level of participation in the implementation of activities, particularly « risky » activities, exposed to possible shortfalls in implementation.

33. Develop reporting dynamics between GAVI and the GAVI-HSS National Coordination Team by building a relationship and level of dialogue helping the coordination team to toll out HSS better whilst preserving its spirit, and encouraging mutual understanding of the logic of intervention and respective constraints.

For GAVI and the Ministry of Health

34. Enrich the GAVI-HSS national coordination team with experiences of GAVI-HSS in similar countries.

# SECTION 8 | ANALYSIS OF THE APPLICATION PREPARATION PROCESS FOR GAVI HSS2 GRANT

This section addresses an additional request by GAVI to verify to what extent certain issues raised during the design and implementation of HSS1 were spontaneously considered. The evaluation team has conducted a review of the application itself, and, through interviews with key informants, reconstructed the main phases of development of the application submitted to the HSS2 process. However, it should be noted that this evaluation does not include an analysis of the actual content of the proposed program bringing out a new analysis of intervention. It only concerns the approach taken by stakeholders in Burkina Faso in the design and submission of the application.

## 8.1 MILESTONES

It is difficult to determine the exact date when the preparation of the application started. First exchanges were initiated in 2011 (approximately in the mid-term of HSS1) at a peer review workshop organized by GAVI. The preparation of the application was carried out by a team from the Ministry of Health under the leadership of GAVI HSS focal point and the Directorate of Studies and Planning of the Ministry of Health (now Directorate General for Research and Sectorial Statistics), Technical Department in charge of the coordination, planning monitoring and evaluation of health programs. The HDSP Steering Committee, which assumes the role of the HSCC, approved a first draft proposal in March 2012. The application was submitted to GAVI for the first time in March 2012. At the request of the GAVI Secretariat, the project duration was reduced from 5 to 3 years. The Independent Review Committee (IRC) commented and requested that the proposal be revised.

The revised proposal was based on a participatory process involving many exchange of documents between stakeholders. The drafting committee was reconstituted. An in-depth review was carried out for the first time at a weeklong workshop in July and August 2012. The reconstructed proposal was subsequently distributed, discussed and commented on by the stakeholders at the national level and by the technical and financial partners (WHO and UNICEF). After the final approval of the Ministers of Finance and Health, a revised application was submitted in August 2012. In December 2013, GAVI approved the application subject to clarification of "level 1". Decision notifying GAVI's approval of the application to provide support to Burkina Faso was received in March 2013.

## 8.2 PREPARATION PROCESS

The key features of the process are shown in the following table. This is structured on the principal challenges identified in the GAVI HSS 1 evaluation.

**Table 11: Appreciation of the process by the evaluation team**

| Key processes and critical aspects identified in the HSS1 | Facts and appreciation | Level of certainty |
|---|---|---|
| **The process of preparing the application, was it inclusive?** | | |
| Internally | Long participation process: The core of the preparation team composed of experts from the central level. Attribution of specific roles to the team members. Sharing of work. Consolidation under the responsibility of the GAVI HSS focal point. Programmatic choices made by consensus. Drafts submitted and discussed at workshops involving different levels (central, regional, district). Review and adoption by consensus. | Information provided by the interlocutors. Facts not verified, yet credible |
| Stakeholder participation in the development of the application. | Limited. Partners were approached, but their involvement was too less .WHO participated in the last review meeting of the application (August 2012). The Ministry informed GAVI after rejecting the first application. | |
| Involvement of regional and district levels. | Yes. | |
| Involvement of the civil society. | Two persons representing the civil society and another representing the private sector were among the members of the drafting committee. The team does not know their level of | |
| **The process of identification of bottlenecks, has it been** | | |
| | The process seems to have been based on three parallel lines of actions:<br>□□Monitoring the Recommendations of the drafting guide that requires a current status report on the immunization.<br>□□Taking into account the views and conclusions expressed in various reports and relevant documentary sources, including the report on effective vaccine management (EVM 2012).<br>□□Large internal consultation (central, regional and district).<br><br>Final arbitrations resulting from a process of consensus. According to the coordinator of the drafting committee, "During the process of preparation and adoption of the new submission of Burkina Faso, all decisions were made by consensus, taking into account national priorities on vaccination, results of the evaluation on effective vaccine management as well as equity and gender | Information provided by the interlocutors. Facts not verified, yet credible. |

| Key processes and critical aspects identified in the HSS1 | Facts and appreciation | Level of certainty |
|---|---|---|
| **Is there a better anchoring of HSS with immunization activities?** | | |
| General approach | Anchoring in vaccination is acuter. The very title of the application reflects this desire to make the link between planned activities and improving immunization coverage more obvious. The concern for a strong focus on immunization coverage was taken into account in designing. This resulted in the elimination of activities that were not adequately linked | Evidence provided by examining the contents of the application |
| Involvement of the e directorate of prevention by immunization (DPI) | Preparation of the application: three of the 10 members of the drafting committee come from the General Directorate of Health and Family, including two of the DPI. Their role was among other things, to ensure proper alignment of contents and requirements and programming of the DPI.<br><br>HSS2 project management: two DPI members who are part of the technical team are now responsible for the implementation of HSS2 (Monitoring Committee). This is an important provision because for the HSS1 DPI was involved in the planning but not in the | Facts not verified, yet credible |
| **The institutional anchoring of HSS2, is it secured and** | | |
| Clear responsibilities, were they defined for the monitoring and follow-up of HSS2? | Yes. The decree dated February 4, 2014 appointed a monitoring and evaluation committee that will remedy the weaknesses identified during the HSS1 project. It is coordinated by the former focal point of HSS1, which should ensure good continuity and preservation of institutional aide mémoire of the project. The terms of the decree reproduced here below are explicit:<br><br>Article 1: A monitoring and evaluation committee has been created at the MOH for the new submission by Burkina Faso to the World Alliance for vaccines and immunization (GAVI) for strengthening the health system related to immunization.<br><br>Article 2: The monitoring and evaluation committee is responsible for:<br>- Planning the activities o the proposal<br>- Monitor the physical and financial execution of activities under the proposal through quarterly field visits<br>- Play an intermediary role with GAVI<br>- Prepare quarterly reports to be submitted to the steering committee PADS<br>- Make proposals and/or recommendations for the implementation of activities. | High |

| Key processes and critical aspects identified in the HSS1 | Facts and appreciation | Level of certainty |
|---|---|---|
| **The choice of scheduled activities, is it convincing?** | | |
| Has the scattering of activities been avoided?<br>Has GAVI honoured the principle of alignment? | The evaluation team has not commented. A detailed analysis of the contents of the application HSS2 is deemed necessary. We assume that this content has been reviewed and approved by the national party and GAVI to the satisfaction of the stakeholders. | None |
| | Yes, it appears that the situation analysis, program choices and arbitrations were directed and mastered by the national party. | High |
| Activities that were not part of r a consensus during HSS1 were revised. | - Support to DQS: HSS2 maintains the principle of supporting DQS activities. This question has been the subject of repeated discussions, and there was a "debate" about it. Finally, the HDSP steering committee (playing the role of CCSS) has chosen to maintain this activity according to the so-called “DQS by peers”. For, it was observed that the district had a great need for support. We are told that such compromises have been the subject of a consensus.<br>- Community activities: Community activities directly and clearly related to vaccination only are retained. Other activities (support to contracting for example) are no longer part of the programming. | Facts not verified, yet credible |
| **Have steps been taken to improve the day-to-day activities?** | | |
| Has the mandate for coordination been entrusted to clearly | Yes, a monitoring and evaluation committee will drive HSS2 and a coordinator has been appointed. | |
| Is a better management of construction activities predictable? | - Less number of constructions is planned in HSS2. Centres built during HSS1 will be equipped. Construction activities will be limited to a store in response to a need identified as a priority. The burden of construction supervision will be lower.<br>- The coordination team is aware of the problems that occurred during the HSS1. It attributes part of the problem to the lack of foresight in preparing contracts, bid management, etc. Steps have been taken for a better anticipation and prior preparation for the activities. | Can be verified on demand<br>Facts not verified, yet credible |

| Key processes and critical aspects identified in the HSS1 | Facts and appreciation | Level of certainty |
|---|---|---|
| Monitoring the progress of activities, will it be improved? | It is expected that the creation of the Monitoring - Evaluation Committee will have a beneficial effect on monitoring the progress of activities and resource consumption. However, it is important to ensure an optimization of interactions between DGSSS and HDSP and create conditions for the emergence of a real and recognized leadership in the | Cannot be verified at this stage. |
| Will the programming be more flexible and responsive to the needs? | - In this regard, the willingness of the coordination team is obvious. It recognizes the limitations of existing multiannual micro-planning works (see evaluation report) and would like to have more flexibility. It feels already that the application developed in 2012 and approved more than a year later should be revised.<br><br>- The revisions to be considered during the project implementation can be of different kinds. It can be of simple reprogramming of activities (activities carried over from one year to another for example, or requiring additional or fewer resources than expected). But it can also concern new activities, responding to the needs and emerging bottlenecks. It is also possible that initially identified needs were fulfilled. For example, vehicles whose acquisition has been programmed for supervision purposes were acquired in the meanwhile using other funds for some districts.<br><br>- These statements reinforce the findings of the evaluation team to the effect that the process for the planning/reprogramming of existing activities is not appropriate to the nature of this project to be anchored in a problem solving process (the bottlenecks), closely related to circumstantial objectives and existing/emerging problems.<br><br>- The team suggests to revise again the current planning process, to carry out an annual rather than a multi-year programming of activities, and to include these reprogramming in a strategic plan that cover project period. Else, some of the difficulties encountered in | Facts not verified, yet credible<br><br>Not applicable (Analysis of the evaluation team) |
| **Was the communication with GAVI acceptable?** | | |
| | - The permanent presence of interlocutors on both the sides greatly facilitates the exchange, arbitrations and feedback processes.<br>- Cooperation between the Secretariat and the national team preparing the application has been relatively limited, but apparently effective. | |

1) *The evaluation team was pleasantly surprised by the quality of the preparation of the application. Many issues identified during GAVI HSS1 were spontaneously taken into account during the preparation of the application and discussions for approval.*

2) *GAVI involvement in the preparation of the application was limited but within the expected standards. The alignment principle was respected. However, the technical and financial partners seem to have little involvement.*

3) *Remarkable progress was seen in the steps taken to ensure better institutional anchor, refocus the demand on immunization and to guarantee greater involvement the directorate of prevention and vaccination. The appointment of a monitoring and evaluation committee and a coordinator are important decisions that help better implement the GAVI HSS2 program and improve its visibility and management on a daily basis. It should be stressed that this designation followed the participatory workshop in which the evaluation team recommended the rapid identification of a body in charge of technical management and monitoring of GAVI HSS activities.*

4) *The reduction in construction activity and a proactive attitude suggest that the rate of resource utilization could henceforth improve. Both the monitoring and evaluation committee and the GAVI Secretariat should, however, be vigilant about this and be more responsive.*

5) *The level of preparedness (readiness) of the Ministry for GAVI HSS2 is considered much higher than for GAVI HSS1.*

6) *By now, the program of activities must be reviewed. The main weak point of the application is the excessive regulatory and technocratic nature of the programming. The team continues to believe that a more flexible, adaptive and less standardized planning model would be vital for a project the essence of which consists in meeting the needs related to eventual bottlenecks.*

7) *National authorities appreciate the HSS GAVI program and the relevance of the latter is in no way questionable. The refocusing of immunization activities is more in line with the GAVI institutional mandate and locally increases the visibility and acceptability of GAVI HSS. Interactions between GAVI and the National Partners are good and facilitated by the permanent presence of interlocutors on both sides.*

# CONCLUSION

The team believes that the GAVI support to the HSS program in Burkina Faso provides a real potential for strengthening immunization activities. It states that the planning for the Phase II of the GAVI HSS support takes into account certain lessons learned from the previous phase.

The evaluation helped to bring out the strengths and weaknesses of this intervention. It provides precious information for the second GAVI HSS intervention being launched. Given the positive results, the team essentially observes that: (i) the alignment principles were clearly and carefully respected by GAVI. The situational analysis, evaluation of requirements, proposed solutions, strategic and operational choices, priority intervention areas and the duration of the HSS GAVI program were all effectively coordinated by the Ministry of Health; (ii) the degree of confidence in implementing the program is generally high, particularly at peripheral level, through a successful coordination with the district plans; (iii) the implementation enjoys a certain amount of flexibility. In fact, considering the difficulties that are expected in the implementing certain activities, a few changes have been made including abandoning of certain activities.

The team also notes that certain points are being improved: (i) institutional anchoring was inadequate and reduced the visibility of the intervention; (ii) the commitment of financial resources was incomplete and the residual budgets were carried forward from one year to another, mainly because of the low level of implementation of construction activities and equipment; (iii) as in other HSS GAVI recipient countries, the link with immunization services (DPI) was very much limited.

In spite of the observed shortcomings, HSS GAVI's program in Burkina Faso generally proved good. However, funds allocated for the implementation were not been fully consumed, demonstrating systemic challenges that were not anticipated during the design of the intervention and its implementation.

Lessons learned from the evaluation have led the team to formulate recommendations to the Ministry of Health and GAVI on the vision, the planning process, and the link with immunization activities, anchoring, coordination and monitoring by the Ministry of Health and relationships with GAVI and the financial partners for HSS GAVI support. Moreover, the Ministry has not expected to implement some of these recommendations to GAVI HSS 2: creation, by virtue of the decree dated February 4, 2014 (following the exchange preliminary results of the evaluation) of a technical committee in charge of the implementation process, appointment of a coordinator, greater involvement of the DPV (two of its representatives are included in the technical committee that was created), changes in certain activities (DQS, community activities), less planned constructions, and choice of construction sites near urban centers.

The team believes that the level of preparation ("readiness") for GAVI HSS2 is higher than for GAVI HSS1. During the implementation thereof, special attention should be given to recommendations related to key identified issues. One should ensure: (i) to provide an effective and strengthened technical leadership for the realization of the intervention; (ii) to use planning processes that are more flexible, with the possibility of annual reprogramming taking into account the changing needs that could arise due to potential bottlenecks; (iii) to increase the response of the GAVI monitoring system.

The evaluation team mandate was successfully executed and facilitated by an effective, committed participation of the stakeholders. In addition to the positive comments made by the Ministry of Health on the participatory approach adopted throughout the evaluation, the National Party has stressed on the importance of the lessons identified and the recommendations made. The initiative by the monitoring and evaluation committee to invite the team to present the results of the evaluation to the Minister and his main collaborators testifies to this review and reflects the concern of the monitoring committee to ensure that the recommendations are effectively implemented within the framework of the implementation of GAVI HSS2.

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## ETHICAL ENDORSEMENT

Positive opinion by the ethical and research committee on the health situation in Burkina Faso

September 20, 2013.

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[i] Greene JC. Mixed Methods in Social Inquiry. San Francisco: Wiley; 2007.