



GAVI Health Systems Strengthening Support Evaluation 2009

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Volume 1 Key Findings and Recommendations

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Abbreviations and acronyms

APR	Annual Progress Review
DPT3	3 rd Dose of Diphtheria, Tetanus & Pertussis Vaccine
DRC	Democratic Republic of Congo
EPI	Expanded Programme of Immunisation
FMA	Financial Management Assessment
GAVI	The GAVI Alliance
HMIS	Health and Management Information System
HSCC	Health Sector Coordination Committee
ICC	Inter-Agency Coordination Committee
IHP+	International Health Partnership Plus
IRC	Independent Review Committee
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	Non-Governmental organisation
PMU	Project Management Unit
SWAP	Sector-wide Approach
TAP	Transparency and Accountability Policy
TOR	Terms of Reference
UNICEF	United Nations Children's Fund
WB	The World Bank
WHO	World Health Organisation

1. Summary of recommendations

This section - prepared for the busy reader - summarises the main recommendations relevant to the three areas where this evaluation was expected to contribute to:

- 1 To inform the GAVI Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
- 2 To improve current and future implementation of GAVI HSS
- 3 To enhance the quality of the GAVI HSS evaluation planned for 2012.

To inform the GAVI Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window

The decision to fund health systems strengthening (HSS) support to improve immunisation and related services was bold and innovative. It was a valid decision and remains valid today. Evidence from the country case studies to date indicates that:

- countries have identified some of their real constraints on expanding services coverage, and have selected sensible objectives in reducing those constraints
- programmes are very much country driven, and most are aligned with national policies and sector strategies (if not so much with country processes and planning cycles)
- the flexibility of GAVI HSS enables countries to design programmes addressing what they see as their real needs, rather than problems identified externally
- countries are beginning to achieve results in terms of getting programmes underway, although weaknesses in tracking the use of HSS resources make it difficult to assess how well this is being done.

Because the program has been implemented for a short period of time only, it is not yet possible to detect changes in outcomes/impacts, even if they occur. What will be possible is to link GAVI HSS funded interventions to outputs that can serve as plausible proxies for outcomes, but this will require a substantial revision of the HSS monitoring and annual review processes.

The performance of GAVI HSS can be improved by building on its strengths to introduce a number of changes to its business model. With these changes in place, many countries will offer opportunities for further investment in HSS activities that are likely to increase the coverage of immunisation and other child and maternal services. Also, these strengths and the improvements needed should provide important guidance for the development and operation of the proposed Joint Funding Platform for health systems strengthening.

Options for improving current and future implementation of GAVI HSS

GAVI HSS funding has generated tremendous demand from many low-income countries because it can be used for priorities they identify, is delivered through a relatively straightforward and non-competitive application process, and is predictable. It has been launched with considerable speed, and in less than 3 years \$524 million has been committed to 44 countries, and \$255 million disbursed to 36. Although it is early days, indications are that countries are beginning to get relevant activities underway, and that GAVI HSS funding has resulted in a greater focus on needed health systems improvements and on innovations that might not have received funding otherwise.

However, for countries to maximise the opportunities offered by HSS funding and for HSS funding to be performance based the GAVI business model needs to be adapted to the specific features of HSS interventions. This evaluation has identified weaknesses in three main areas, and swift action by the GAVI Alliance and its Secretariat is needed. Firstly, insufficient technical support is being provided to HSS grants. Secondly, proposal assessment is not identifying resulting problems. Thirdly, weak annual review and reporting are hindering the results-oriented ambitions of the GAVI HSS model. These are elaborated below.

GAVI HSS operates through a partnership model based on a distribution of tasks among Alliance partners that, in the case of the Alliance “technical partners” (WHO, UNICEF and World Bank), are outlined in workplans. In practice, this arrangement is not resulting in the high quality technical support for the GAVI HSS process that is needed. The relevance and quality of HSS technical support that partners provide to countries are variable and concentrate on the proposal design and pre-review stages, while it was found to be insufficient or weak for start up and implementation, and for ensuring monitoring mechanisms are in place that produce adequate information for country programme management and for external assessment. Neither the financial nor the programmatic risks are being controlled adequately through the partnership model, and it is clear that the GAVI cannot rely solely on other institutions within the partnership to control its HSS-related risk and needs the Secretariat to take a more proactive role.

The GAVI Alliance Secretariat must take more control of financial and programmatic aspects of its HSS support to reduce risk, to ensure effective investments, and to achieve more accountability whilst retaining its welcome flexibility for countries. This requires more pro-active and differentiated engagement with countries by the GAVI Secretariat throughout all stages of the HSS process, with support tailored to countries’ individual needs.

In turn, this requires more in-house HSS capacity in the GAVI Secretariat to assess a country’s needs for technical support and to commission it appropriately and in consultation with countries. GAVI could build this capacity in its Secretariat as a matter of urgency, combining development of a small HSS unit with strengthening HSS support across relevant departments and, to minimise in-house staffing, with arrangements for contracting technical expertise to ensure that this is the best available.

This enhanced capacity and country-differentiated approach should focus on improving programme design, and especially on incorporating stronger specification and costing of plans for monitoring and reporting, start up and implementation, and financial management and accountability.

A second area for improvement in the current GAVI HSS process concerns the assessment of proposals for grants. Though perhaps providing a degree of impartiality, the Independent Review Committee (IRC) process requires redesign. In its current form it is too distant and removed from country realities to provide a realistic evaluation of proposals, and is unable to provide much useful support to countries to improve programme design.

One option would be a modified process that takes place more in countries. As deployment of IRCs at country level would be unwieldy and expensive GAVI might consider to contract this function to an intermediary able to provide and quality control a team of experts, one or two of whom would assess proposals in country, working supportively with country teams to improve programme design, but ultimately responsible for providing an objective assessment to the GAVI Secretariat.

Thirdly, there is room for improving the performance review process. Despite worthy efforts by committee members, the IRCs assembled annually in Geneva are unable to interrogate countries on the Annual Progress Reviews (APRs) submitted, to validate the data these reports contain (data should be more thoroughly validated in country, but is not), or to contribute meaningfully to improving the monitoring and reporting capacity and process. As with grant assessment, performance review should be undertaken more at country level. Again, since it is not possible to convene IRCs in each and every programme country annually, it may be advisable to contract the performance review function to an intermediary able to supply one or two HSS experts to undertake this in country and tailor it to country planning, review and budgeting cycles.

We estimate that the costs of implementing these recommendations would be roughly similar or even less than those currently paid by GAVI to technical partners and for convening the IRCs.

In addition, GAVI HSS should:

- Ensure that the rounds-based approach for assessing new proposals does not conflict with the need for approval and disbursement of HSS grants to be synchronised with country planning and budgeting cycles.
- Require countries (and those providing technical support) to adopt indicators that measure HSS outputs not just immunisation and health outcomes/impact. These should link objectives to activities and outputs e.g. increased service uptake, more regular supervision visits, reduced attrition rates in remote facilities. They should be programme-specific and realistically within individual country capacity to monitor rather than an indicator set common to all GAVI HSS funded programmes. This will improve programme monitoring and therefore programme performance, and allow better attribution of results to GAVI HSS inputs. Current core GAVI HSS outcome/impact indicators are affected by too many confounding variables or too removed from the downstream interventions that the GAVI HSS typically supports.

- Provide technical support to work retro-actively with countries with current grants to achieve these improvements in indicators and monitoring arrangements.
- Replace the HSS Task Team with a small HSS advisory team chaired by GAVI.
- Work proactively with countries on addressing all the above issues and consider a delay in the approval of new HSS submissions whilst these proposed changes are put in place. Existing grants should continue (barring major misuse, etc) and strengthened, and all second generation HSS grants should incorporate the changes proposed here to benefit from the learning gained from this evaluation and from other sources to date.

To enhance the quality of the 2012 evaluation

Case studies undertaken in this 2009 evaluation suggest strongly that it will be difficult to attribute changes in currently specified outcome indicators to GAVI HSS inputs, even at the time of the planned 2012 evaluation. What may well be possible is to link GAVI HSS inputs to the implementation of activities and the achievement of outputs as plausible proxies for outcome indicators.

The 2012 evaluation should undertake purposively selected, in-depth case studies using mixed-methods research rather than a large-scale statistical evaluation involving all or a large sample of GAVI HSS countries. Individual case studies would still explore input-outcome linkages but using disaggregated data at regional, district or facility level, and aim also to compare intervention sites with non-intervention sites.

To facilitate this, action is needed now to ensure that countries are collecting and reporting data adequately. GAVI HSS should help commission technical support to work with selected countries with existing grants and in the preparation of new grants, developing an agreed minimal set of output indicators and, where possible, outcome indicators that are more appropriate to HSS changes, acceptable to GAVI, and deliverable using existing data gathering and compilation procedures, or slightly modified ones.

2. Background

The GAVI Alliance was launched in 1999 to increase immunization coverage and reverse widening global disparities in access to vaccines. Recognizing that achieving immunization coverage is dependent upon strong service systems, the Alliance Board took the first steps to expand GAVI support to health systems strengthening (HSS) in early 2005.

The initial proposal recommended that the HSS window remain open to all eligible countries for the 2006-15 period, with a maximum funding level of US\$1.8 billion. In December 2005, the GAVI Alliance and Fund Boards agreed to invest an initial \$500 million in the HSS Window. The 2005 Board Decision also called for evaluations of the window in 2009 and 2012, as proposed in the investment case.

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

In February 2008, the GAVI Board approved a further increase to the GAVI HSS window of \$300 million. As of June 2009 \$524 million was committed to countries and \$255 million was disbursed, which leaves a balance of \$265 million in committed HSS grants to be disbursed in future. Much of the coordination of the HSS investment is through the Alliance partners, while at the global level a GAVI HSS task team provides oversight of the HSS work plan.

This GAVI HSS Support Evaluation 2009 was commissioned in February 2009 by the GAVI Secretariat to HLSP through competitive tendering. It covers all countries for whom HSS funding had been approved by December 2008. It's findings are based primarily on 21 country case studies (11 undertaken in country: Burundi, Cambodia, Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia, and 10 desk studies: Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen), and interviews and questionnaires consulting a wide selection of individuals involved in the GAVI HSS process (see Annex 1). The evaluation methodology is outlined in Volume 2, Annex 6.

This evaluation is presented in three main volumes:

Volume 1 – an extended summary of key findings and recommendations

Volume 2 – a full evaluation report providing details and integrated evidence

Volume 3 – the individual country case studies (3a and 3b), and the evaluation study guidelines and summarised responses to questionnaires (3c).

Volume 2 is structured around the five main questions identified by GAVI for this evaluation:

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

The structure of this Volume is slightly different from Volume 2 in order to enable faster reading through findings and recommendations.

3. What is GAVI HSS achieving and likely to achieve?

GAVI HSS funding was made available to help countries overcome or reduce health system constraints on the delivery of immunisation and related services. Countries can use the funding flexibly but GAVI established some principles based on good practice for effective aid: that programmes should be country led addressing problems identified by countries themselves, aligned to country policies and plans, harmonised with other efforts to improve health systems, predictable allowing countries to plan, additional and not displacing government funds, designed through an inclusive and collaborative process, catalytic in stimulating other improvements, innovative in seeking new and better solutions, results oriented in clearly linking investments to results in immunisation coverage, and sustainable by countries financially and technically.

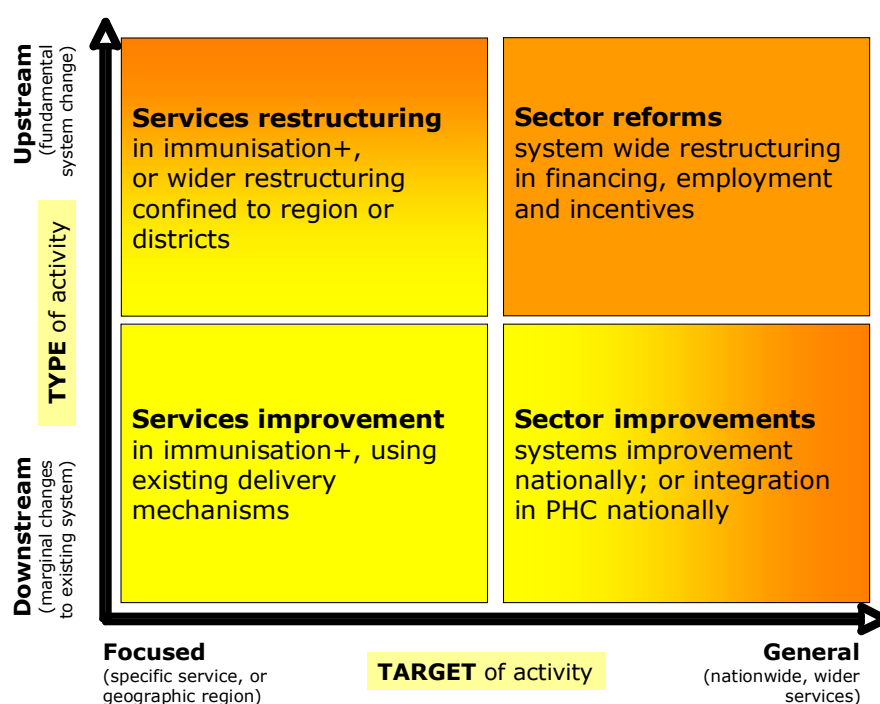
Although not exclusive, three themes were identified to guide applicant countries:

- health workforce mobilisation, distribution and motivation at district level and below
- drugs, equipment and infrastructure supply, distribution and maintenance
- organisation, monitoring and management of health services at district levels and below.

3.1 The focus of interventions

Countries have selected a variety of uses for GAVI HSS grant funding, but almost all have pitched most of the activities 'downstream' in immunisation and Maternal and Child Health (MCH) services delivery and in immediate support to delivery of those services, and sometimes in selected districts, rather than 'upstream' in sector-wide change or reform (see Figures 3.1 and 3.2).

Figure 3.1: Upstream – downstream HSS activities



Predominantly, country programmes cover training, strengthening management and supervision, and procuring supplies and equipment and improving their management and many include improvements to information collection and use (see Table 3.1). Few countries have tried to use GAVI HSS funding for more fundamental 'upstream' change in health systems, although some have opted to use funding to improve aspects of the Health and Management Information System (HMIS).

This finding is broadly consistent with that of previous studies which found that, although countries had identified more upstream than operational level constraints, they proposed to allocate much more of their GAVI HSS grants to operational than to upstream interventions. [Hill et al. (2007); WHO/UNICEF/GAVI Alliance (2008)]

Figure 3.2: Case study countries by upstream – downstream activities

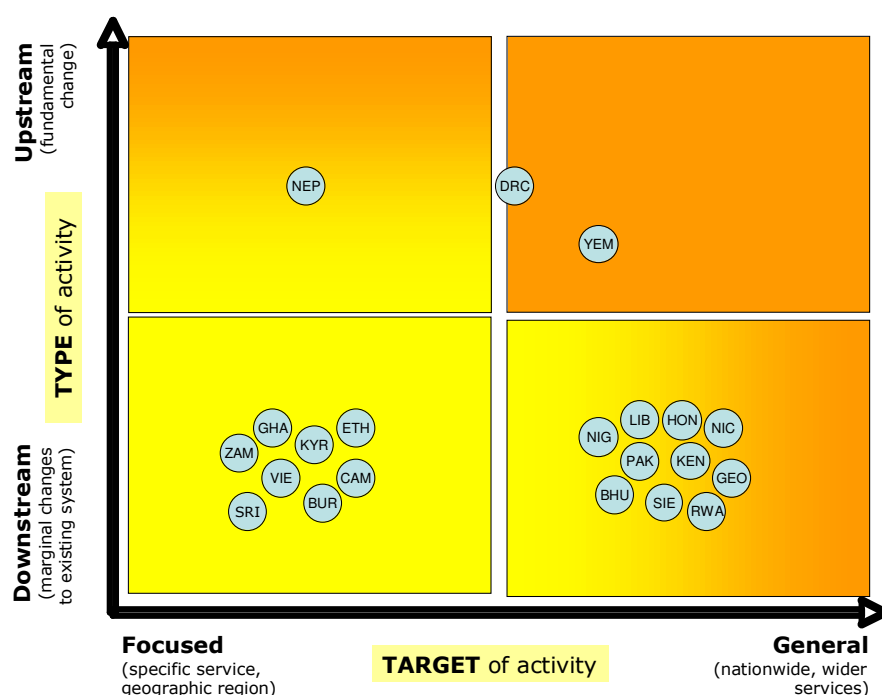


Table 3.1: Categories of Intervention across 21 countries studied

Categories of intervention	BUR	CAM	DRC	ETH	KYR	LIB	NEP	PAK	RWA	VIE	ZAM	BHU	GEO	GHA	HON	KEN	NC	NG	SRI L	SIE L	YEM
Health workforce mobilization, distribution and motivation																					
Incentives & performance based schemes	√	√	√		√			√	√	√	√		√							√	√
Basic and in-service training	√	√	√	√	√	√	√	√	√	√		√	√	√		√	√	√	√	√	√
Quality assurance initiatives		√												√			√		√		
Organisation and management of health services																					
Performance based contracting (e.g. with NGOs, CSOs, private providers)		√			√																
Improving HMIS	√		√	√		√	√	√		√				√			√	√	√		
Monitoring and Evaluation		√	√	√	√	√		√	√				√	√	√	√					√
Support for provincial and federal levels in supervision, monitoring and evaluation of health system performance & support to external review and evaluation								√													
Operational research		√																			
Strengthening management performance and supervision practice at all levels	√	√	√	√	√	√		√	√	√		√	√	√	√	√	√	√	√	√	√
Identifying and improving service provision and utilization for 'hard to reach' populations		√					√	√						√	√	√	√			√	√
Supporting implementation of more coordinated and integrated delivery of services (including immunization and other child health services)	√	√	√			√		√	√						√	√					√
Financial management improvements		√	√		√									√	√						√
Influencing demand for care	√	√			√	√			√												
Innovative strategies to improve health services		√			√					√				√							
Improving communications email internet computers etc							√					√									
Advocacy activities aimed at policy makers, parliamentarians, local govt. officials and the public					√																
Supply, distribution and maintenance systems for drugs, equipment and infrastructure																					
Supplies management (inc. vaccines and related supplies)			√			√			√	√				√					√		
Equipment management (e.g. cold chain etc)			√	√	√				√	√	√			√	√	√		√	√	√	
Transport management					√	√	√				√		√	√	√	√		√	√	√	
Infrastructure development			√	√	√		√	√	√		√								√	√	

The downstream spending focus is not surprising: service delivery level interventions are more manageable, reflect the predominant role of EPI departments in programme design, and are the emphasis of GAVI HSS guidelines and intentions, whilst more systemic change must be more politically driven and requires substantial investment. Neither is downstream spending intrinsically problematic: these downstream interventions are likely to improve the quality and quantity of services delivered where they are being applied. They are broadly consistent with the 'Reach Every District' Strategy that has been promoted and supported in many countries since 2002. By and large countries are making good use of GAVI HSS funding, with modest but realistic objectives for the amount of funding available. It must be recognised though that the HSS money will not go very far in terms of expanding interventions on the scale needed to make big impacts on problems of de-motivated health workers, inadequate management skills and unpredictable financing in the districts.

Achieving results on a larger scale and with long-term sustainability, however, requires not only larger investments but also significant upstream changes in the way public sectors are financed, staff employed and incentives applied. It requires good sector governance, solid planning, budgeting and financial management, and effective aid and sector coordination. Without progress in these parameters, delivery gains in specific services may be fragile. This evaluation suggests that GAVI HSS should continue its efforts to strengthen delivery systems for immunisation and related child and maternal care. At the same time, however, it should also now engage energetically with others with common objectives of building strong health systems across the board able to deliver an affordable range of health interventions whilst maximising synergies and efficiencies. These joint

efforts will need to move upstream. A more complete discussion of these matters can be found in Volume 2 (3.1.1 and 3.1.2).

3.2 Prospects for detecting results

3.2.1 Linking interventions to outputs and outcomes

The first round GAVI HSS countries confirmed receipt of funds in April 2007. Given the limited period over which the projects have been implemented, it was always considered extremely unlikely that this evaluation would be able to identify causally related changes in outcomes in terms of national immunisation coverage rates, let alone changes in impacts in terms of reduced mortality rates. In fact, the detailed country case study work undertaken indicates that linking HSS inputs causally with changes in outcomes or impacts will remain extremely problematic, even for the 2012 evaluation (see section 3.2.2), and that the rigorous attribution of any changes that might be observed at national level to GAVI HSS funding specifically will be impossible, because, *inter alia*:

- in all countries, GAVI HSS is one of a number of sources of support for system strengthening components that have similar goals and are being applied simultaneously – including government support
- GAVI HSS funds may support only some of the components necessary to achieve a change in a specific outcome, and
- GAVI HSS is not funding a standardised intervention that can be compared across countries.

What may be possible is to link HSS interventions - and inputs funded by GAVI HSS in particular - to the implementation of activities aimed at achieving output objectives. For example, it may be possible to link GAVI HSS funding spent on additional training for middle level managers in supervision and monitoring of MCH workers, to outputs or even outcomes in selected districts or health facilities. Outputs might include changes in numbers trained and in the level of their skills, or in numbers of supervisory visits made. Outcomes might include changes in activity levels of MCH workers or in uptake of services by population, in immunisation rates or pre-natal visits. Comparisons might be made with otherwise similar districts in which these interventions have not yet been made.

3.2.2 Implications for the 2012 evaluation

The 2005 Board Decision to fund HSS support called for evaluations of the window in 2009 and 2012. The 2009 evaluators were asked to assess *what needs to be done, and by when, at country, regional and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012* (Objective 5 of the Request for Proposals). In response to that a draft set of TOR have been submitted separately to the GAVI Alliance Secretariat, and relevant issues are discussed in Volume 2 (section 6) of this evaluation.

As conceived currently, the 2012 evaluation aims to assess the links between GAVI HSS investments and the three core outcome/impact indicators: national DTP3 coverage, the number/percentage of districts achieving $\geq 80\%$ DTP3 coverage, and the under-five mortality rate. The ambition is to assess the extent to which changes in these indicators might be attributable to activities funded by

GAVI HSS. As mentioned above, the case studies undertaken in this 2009 evaluation suggest that this will be a highly problematic activity and that it is equally important to explore implementation processes.

The 2012 evaluation will offer an extremely valuable learning opportunity for GAVI HSS, and for any joint funding platform for health systems strengthening that may emerge from current discussions. The 2012 evaluation should not dismiss the attribution question but should rather shift the focus from 'do GAVI HSS investments work?' to 'what types of GAVI HSS support work best in given contexts?' It would require purposively selected, in-depth case studies using mixed-methods research rather than a large-scale statistical evaluation involving all or a large sample of GAVI HSS countries. Individual case studies would still explore input-outcome linkages but using disaggregated – regional, district or facility level – data, and aim also to compare intervention sites with non-intervention sites. This will also have the advantages (a) of removing at least some of the problems associated with the 'background variation' that is inevitable when assessing widely varying interventions in different countries and (b) of allowing researchers to use available time inputs to obtain the most reliable and relevant data with which to attempt attribution.

A major problem with this 2009 evaluation has been that its ability to track specific indicators was limited by the lack of robust data management systems at country level, making it extremely difficult even to assess the links between activities and proposed outputs, let alone outcomes. There is considerable evidence from the country studies that monitoring of HSS grants has been superficial. There was a failure in many countries to follow up on the M&E framework specified in the original proposal document, with many failing to provide data either on the GAVI HSS core outcome indicators or their own proposed additional indicators. Similar observations could often be made in relation to the overall HMIS.

To ensure the 2012 evaluation will have better data requires some action now. Although ideally countries should use existing national systems to report progress, these systems are generally weak and it would be a very costly and potentially risky strategy to try and bring them to the required level with available GAVI HSS resources. Whilst this may be feasible in a small number of countries, an alternative would be to work with individual countries to develop an agreed minimal set of output indicators that could serve as plausible proxies for outcome indicators that would be both acceptable to GAVI and deliverable using existing data gathering and compilation procedures, or slightly modified ones.

The way to achieve this is through constructive engagement with countries now, providing technical support to ensure data on these indicators will be generated. This should be retro-fitted into selected existing grants and instituted in all new ones through enhanced technical support during design as discussed in this report. It is recognised that the data issues raised above are typically even worse at regional, district or facility levels but this disadvantage would be outweighed by the possibility of undertaking analysis of input-output-outcome links within a relatively uniform context and for a relatively uniform intervention. It will therefore be essential to include a consideration of the availability and reliability of data at sub-national levels in this engagement with countries. A

review of other potentially useful sources, for example supporting DHS surveys to over-sample in relevant districts, could also be undertaken.

3.3 Evidence of progress

The evidence available so far on progress with HSS grants from country case studies (see 2.5 in Volume 2 for details) is that:

- countries have identified some of their real constraints on expanding services coverage, and have selected sensible objectives in reducing those constraints
- programmes have been very much country driven, and most are quite well aligned with national policies and sector strategies (if not so much with country processes or annual planning and budgeting cycles)
- the flexibility of the GAVI HSS approach has enabled countries to design programmes around what they see as their real needs, not constraining them to preconceived problems or solutions
- countries are beginning to achieve results in terms of getting programmes underway, although weaknesses in tracking the use of HSS resources make it difficult to assess how well this is being done as yet.

The case studies indicate that the GAVI HSS window is resulting in country led, flexible and reasonably predictable support for HSS for immunisation and child and maternal services, which would not have happened or would have happened more slowly without GAVI HSS (see Volume 2, section 5). It may also have resulted in greater support for HSS than would otherwise have been the case, given that funding from alternative sources is likely to have been applied more vertically and thus resulted in further undermining of sector systems and processes, or might never have materialised and would have been lost to the sector. GAVI HSS has been keen to follow government priorities but its alignment and harmonisation with government planning, monitoring and reporting systems has been weak, although stronger in countries with a functioning SWAp.

However, GAVI HSS may also have promoted fewer upstream approaches than might have been possible, and may have reduced the perceived need for more fundamental health system change. At the same time weaknesses in other areas such as the lack of adequate M&E, a lack of focus on sustainability and the very willingness to be so flexible, mean the approach is high risk with little guarantee that results can be demonstrated even where they occur, and there are concerns that benefits might not be sustained.

3.4 Conclusion

Many countries are beginning to implement GAVI HSS funded programmes and there are good prospects that many of these will achieve practical improvements in immunisation coverage and in other child and maternal care services. Where these GAVI HSS funded interventions are well integrated within ministry policies and practices, they offer prospects for strengthening primary care

services across the board, a prospect that GAVI HSS guidelines and technical support should emphasise. Where programmes are led by EPI to the exclusion of planning departments, where HSS capacity is weak, or where higher-level coordination bodies are insufficiently involved, there are clear risks that programmes remain too vertical missing opportunities to strengthen primary care delivery and, in extreme cases, risking further weaknesses.

With the various changes made over time to HSS principles and guidelines, GAVI shows that it can be a learning organisation. Unavoidably, however, these changes further complicate assessment of progress.

The objectives of GAVI HSS remain entirely valid and, with the prospect of expanding routine immunisation in low coverage areas, of the impending introduction of important new vaccines, and of the rapidly growing global concern for more substantial and more coordinated health systems support to countries, GAVI HSS has a potentially important role to play. The issues raised by this evaluation are not with the concept of GAVI HSS but more with the details of the process.

4. Issues with GAVI HSS in practice

Experience to date indicates that the decision of the GAVI Alliance to tackle health systems barriers was a good one, the more so in that it was taken when no other global initiatives were making similar support available to countries - or when what support was available was heavily earmarked and burdensome to use. The GAVI HSS window quickly attracted the interest of many low-income countries because it provides access to flexible funding for priorities they identify and through a fairly straightforward application process, and for relatively predictable total funding.

The decision was innovative and, inevitably, entailed challenges and risks. Little was available in the way of proven models for targeting HSS support that would serve the principles of aid effectiveness: being country driven, aligned, harmonised, predictable, inclusive and collaborative, catalytic, equitable, sustainable and results oriented. Understandably, the GAVI Alliance applied the same mechanisms that it had used and tested over several years for delivering other areas of support to immunisation services (ISS), to new and underused vaccines (NVS) and to improve injection safety (INS). But those mechanisms are proving less than adequate for the more complex nature of HSS interventions. This evaluation suggests that whilst GAVI HSS funding has already begun to achieve some success, it could achieve much more if some aspects of the process and the way it is managed are restructured based on learning to date.

4.1 The big issues

Sections 2 and 3 of the full evaluation report (Volume 2) highlight a number of strengths and weaknesses of the GAVI HSS model detected in the case studies conducted. Some of the strengths include the simplicity of the application process, the strong ownership of HSS by countries and the efforts made for HSS design to be an inclusive process. The major general weaknesses in the GAVI HSS programme to date are:

- Although they may be country-driven and inclusive, many proposals are technically and financially weak. Although most focus on important constraints to service delivery, few have convincing linkage between constraints, objectives of the proposed HSS programme, activities to achieve those objectives, indicators that measure them, specifications for how activities will be implemented and how indicators will be monitored. Partly this is a result of confusion sown by GAVI HSS application documents and demands for indicators that are not very appropriate to HSS (see section 4.2.3 below), but mainly it is a result of weak planning capacity in ministries and weak technical support for HSS in countries.
- In some countries GAVI knows remarkably little about how the HSS funds are being used, and this is affecting its ability to assess and manage risk effectively. Whilst much of this problem could be resolved through a more rigorous, redesigned review process (see section 4.2.4 below), much also results from a lack of technical support to countries from GAVI or its technical partners during design and start up to ensure that monitoring and evaluation and reporting

systems are in place, or how they are to be put in place or strengthened as part of implementation.

- Given the innovative nature of the HSS scheme and its considerable size GAVI could be doing more to learn about it. Right now it has limited institutional knowledge or memory of the details of country HSS situations and the fast changing environments in which HSS investments are being made. There is a lack of synthesis of lessons and dissemination of them. Some of these issues might be improved by increasing the number of staff and synthesis of lessons in the Secretariat (see section 5.1). Much of what learning occurs for country-related purposes is through reports by IRC members, and although IRCs have attempted to draw lessons, these are offered from the outside, not generated by the routine business of the GAVI Secretariat and so are not owned and often not acted upon.

4.2 Specific weaknesses and causes by GAVI HSS stages

These are elaborated below under each of the main stages in the GAVI HSS process:

- design, application and approval
- start up and implementation
- monitoring and evaluation
- progress reporting.

4.2.1 Design, application and approval

Not all country programme designs are based on adequate collaboration between immunisation and planning departments, a defect entrenched by decades of vertical programmes support by donors. And there is often insufficient involvement of senior coordinating levels of ministries to ensure ownership, support, harmonisation with other financial support, or coordination with other HSS-related efforts. HSS can be seen as just another source of money for immunisation and, typically, EPI departments are not strong in HSS thinking or programme design. The sign-off of proposals cannot be taken as a guarantee that they are understood and coordinated at a high level or by development partners.

Design-stage work is giving inadequate attention to how implementation will be managed and how measuring and monitoring will be undertaken. In fact, these matters are commonly mentioned in pre-review reports by technical partners or in IRC (design) reports, but they are seldom resolved to the extent that is needed. This is resulting in delays to the start up of implementation, and in weaknesses in ensuring that monitoring mechanisms are in place.

Technical support to the design process was found to be substantial in all case study countries. It was provided mainly by WHO and UNICEF, and it was greatly appreciated by counterparts in the ministries of health. However, the quality and depth of such support was found to be highly variable in extent and quality between countries. In some countries the GAVI preparation grant was very helpful, often used for contracting external consultants. Issues are addressed in section 5.3 below.

The IRC tasked with assessing HSS proposals is the final stage prior to approval and is expected to make the final recommendations to the GAVI Board about the relevance, robustness and alignment of HSS proposals. The evaluation found that whilst the IRC may bring a perceived degree of objectivity into proposal assessment, the input it is able to provide to countries to improve the quality of designs is limited by the availability of written information that countries provide, by the knowledge that individual IRC members have of that particular country at that particular moment, and by the distance between the country and a Geneva-based group. In addition, the rather formal, even rigid process of exchanging clarifications in writing prevents direct engagement between IRC and bidders. IRC members have been able to spot some major problems, inconsistencies and weaknesses in the bottlenecks-objectives-activities-indicators chain. However, their ability to verify data submitted on, for example, clarity of monitoring arrangements, choice of progress indicators, risk management arrangements, and sustainability concerns was very limited. The twice-a-year functioning of the committees is not conducive to continuity in constructive feedback to countries, and IRCs have little or no follow up capacity to ensure that corrections are made or that their recommendations are taken account of.

4.2.2 Start up and implementation

Programme start up has been slow in many countries, caused mainly by assumptions made at design about existence or robustness of implementation, monitoring or financial management arrangements that later proved overoptimistic. Whilst the preference is for countries to employ their existing processes and mechanisms for implementation and for transferring funds to implementing agencies, in practice these are not always strong or even operational, and may require specific support.

This finding does not suggest abandoning existing mechanisms in favour of special ones. It is right that GAVI HSS should seek to use them and thereby assist in their strengthening. But this strengthening will not happen without explicit review of their weaknesses as part of adequate and timely preparation during the programme design period. Typically, however, there is a lack of clarity about implementation arrangements in design preparation work and in the resulting proposals (see Table 4.1 below). Not only does this retard programme start up and effective spending, it risks serious delays throughout implementation until they can be resolved, and may risk programme failure.

Available technical support arrangements for the GAVI HSS process were found to be at their weakest during the start up phase. Skills available are typically not strong in programme management experience and in anticipating trouble, and the case studies detected little useful technical support in practice after design and approval stage.

Table 4.1: Types of implementation weaknesses in HSS proposals from our 11 in-depth case studies

Examples of issues that required more attention at start-up phase	Burundi	Cambodia	DRC	Ethiopia	Kyrgyzstan	Liberia	Nepal	Pakistan	Rwanda	Vietnam	Zambia
Centralised management of HSS Grant makes identification of local technical support needs difficult	✓					✓		✓	✓	✓	
WHO & UNICEF insufficiently involved at start up - unclear role	✓						✓	✓	✓	✓	
The HSS grant management model and links between central and peripheral implementing units may not be strong enough	✓					✓			✓		
Delays in developing Year 1 implementation plan after approval of HSS funding			✓			✓		✓		✓	✓
Greater attention needed on how HSS grant will be monitored and reported about, and the roles of various parties in this	✓	✓	✓			✓	✓	✓	✓		✓
Progress indicators not clear or realistic - sensibility and attribution of proposed HSS indicators needs substantial reviewing		✓				✓	✓		✓	✓	✓
Lack of fit between the Government and GAVI annual reporting systems	✓	✓		✓		✓	✓		✓	✓	
Lack of fit between receipt of HSS funds and first year of HSS implementation		✓	✓				✓	✓	✓	✓	
Late arrival of first HSS tranche			✓					✓			

NB: The 10 Desk Studies were not included in this analysis as insufficient information was available on start-up issues

4.2.3 In-country monitoring and evaluation

One of the more serious findings of this evaluation is that, in its current modus operandi, the GAVI HSS model is failing to show results routinely, even in cases where results are being achieved as detected in this evaluation. One of the problems is what different parties refer to by the term results: does it mean inputs and activities; does it mean process or output indicators? For one thing, the three required GAVI HSS outcome/impact indicators of national level DPT3 coverage, number of districts achieving $\geq 80\%$ DPT3 coverage, and under five mortality rate are not useful measures of the performance of HSS interventions, for reasons outlined in section 3.2.1. A common observation in our case studies was that although countries are free to select other additional indicators, those selected are often not appropriate to measure the outputs from activities undertaken or not available through the monitoring arrangements in place. This becomes particularly visible in the APR reports where the spaces meant to reflect progress on selected indicators –even at output or process levels were often left blank. Weak HSS planning is often at the root of weak monitoring of results, worsened by insufficient assessment at design or start up phases of the monitoring capacity and capability of the organisations responsible for monitoring and HMIS.

Capacity to monitor GAVI HSS is highly correlated with capacity of the country to monitor health sector activity more generally. In this sense, countries with a well functioning health sector-wide approach (SWAp) were found to enjoy a certain advantage when compared to countries with poor coordination arrangements, although the advantage was often offset by either poor integration of

HSS indicators within national monitoring frameworks or by poor communications between EPI and planning departments in the Ministry of Health in countries where HSS was managed mainly by the EPI departments. Even where more appropriate HSS indicators exist (e.g. Cambodia) they are not being used to measure GAVI HSS progress. In some cases key indicators that would measure outputs of GAVI HSS (e.g. supervision in Viet Nam) are not included in the APR indicator list. In decentralised HSS grants, monitoring of inputs, outputs and outcomes is done regularly through HMIS but tends to be aggregated and reported only at national level, which further complicates the measurement of progress in intervention sites.

4.2.4 Programme performance review and results-based funding

The APR process is the cornerstone for GAVI performance monitoring but there are many signs that it should be considerably improved and redesigned when applied to HSS grants. Findings on the functioning of the IRCs made under section 4.2.1 also apply here. Whilst most countries are able to show financial transfers or disbursements made to spending units (facilities, districts, institutions), few can provide any evidence that the GAVI HSS funds have actually been used for the agreed activities. Together with the general absence of audit reports, this means that it is not possible to undertake an assessment of expenditure of HSS funds from the APR.

Secondly, in most cases insufficient evidence is provided in APRs about the sources and calculations used to estimate progress on HSS indicators. IRCs are unable to verify this data and, with a general absence of verification by either the country sector coordination group or the UN technical agencies in country, this APR data is unreliable for performance monitoring purposes.

Rarely are countries able to integrated GAVI HSS activity reporting with other forms of HSS reporting or with the national HMIS. The feasibility and associated costs of activity reporting have not been assessed at design or start-up stages, leading to serious constraints on being able to demonstrate HSS progress in the APRs.

In sum, while the quality of APR reporting may have been considered acceptable in other GAVI windows (GAVI Alliance Evaluation Phase 1 - Abt Associates, 2009), this is not the case for HSS information which is often unreliable, in spite of the efforts and costs involved in gathering it. Similar observations have been made by the IRC itself: "the IRC is of the opinion that the reporting was weak and inadequate in the case of most countries" (IRC Consolidated Report of the APR, 2008). And a 2008 review of the APR model by independent consultants came to similar conclusions in terms of poor reliability of HSS information, and the problems of interrogation and verification by a distant IRC (Martinez, 2008).

An important implication for a performance-based organisation like GAVI is that the review process will need to be strengthened to demonstrate that the funding of HSS grants is based on performance too.

5. Technical support for GAVI HSS

The GAVI Alliance is a global health partnership representing stakeholders in immunisation from both private and public sectors: developing world and donor governments, private sector philanthropists such as the Bill & Melinda Gates Foundation, the financial community, developed and developing country vaccine manufacturers, research and technical institutes, civil society organisations and multilateral organisations like the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the World Bank. Working together, Alliance members achieve objectives that no single agency or group could achieve on their own.

At the operational level, the GAVI HSS process relies on countries receiving technical support from a range of 'technical partners', namely WHO, UNICEF and the World Bank, themselves members of the Alliance. Many of the weaknesses of the GAVI HSS process result from inadequacies in this technical support. These are discussed below, and main recommendations provided in section 6.

5.1 Support role played by GAVI Secretariat

The organisational model adopted by GAVI follows from its origins and self-perception as a funding body rather than an implementing or technical support body, and results in several advantages for an HSS programme. The 'lean' structure allows flexibility to act relatively quickly without excessive bureaucratic layers of decision and approval – although it could be questioned whether the demands by the Board to approve each and every HSS grant and to be able to do this (and twice a year) rather defeats this. GAVI can get money out of the door relatively quickly once a decision is made. In addition, GAVI has attracted some competent and committed staff, and countries have found the Country Support Team helpful.

But the evidence provided by this evaluation and by previous studies (McKinsey, 2008) challenges the assumption that this business model is also appropriate for the new HSS role. HSS is not EPI. Countries are not strong in the skills required to plan, manage and monitor delivery system components that require coordination across various policies and departments. They require support, and given the ambitious time scale and programme size set by GAVI, this amounts to a lot of support.

For HSS, GAVI is not providing sufficient support to countries, and is unable to ensure that others are doing so to the extent needed. Part of this is simply the result of massive in-house under-staffing of the HSS programme, particularly at the level of the GAVI Secretariat. Whilst it is admirable to try to maintain GAVI as a lean organisation and farm out services to others, this does not eliminate the need for Secretariat staff: the contracting out of services still requires in-house staff and skills to do it effectively. GAVI HSS is dealing with substantial sums of money and HSS is complex in that it covers lots of different needs and contexts in different countries, and is managed by country implementers working within country health systems that by definition need strengthening.

A second major issue is that GAVI is not present in countries except through Alliance partners, but this was found insufficient to control its risk by providing pro-active support before things go wrong, or even to identify the need for it. Lessons from this evaluation point to the need for:

- more in-country support for project development and design, for stronger cost and budgeting work, for essential start up measures to address design or system constraints, and
- more in-country assessment and interrogation of performance results, a function that cannot be undertaken satisfactorily at an annual meeting of an IRC in Geneva, or by major evaluation every three years.

It cannot be assumed that WHO or other partners can undertake these functions adequately (see section 5.3) and, in any case, the GAVI Secretariat cannot rely on other institutions to control its HSS-related risk. They have their own needs and agendas. WHO, for example, must work with and retain the trust of governments long term and not risk upsetting them by the directness, challenge and interrogation that is sometime necessary. And WHO is not in control of the GAVI HSS purse strings and will inevitably feel less able to negotiate with governments as a result.

5.2 Support role played by the GAVI HSS Task Team

The Task Team was established to advise the Secretariat, although in practice its reporting function is not clear. In the early days of GAVI HSS, the Task Team played a major role in initiating and getting things done, with members happy to assist where they could and in the absence of a real GAVI HSS staffing.

That has changed as, for one thing, members have realised that GAVI was not building a staff able to do many of the things that clearly needed doing and that had been identified by the Task Team as necessary – the 'tracking studies' result from Task Team dissatisfaction with what is known about grant implementation in countries, for example. At the same time, the Task Team is run by its international agency members and increasingly it seems for the benefit of those agencies with representatives reporting more to their own agencies than to GAVI.

The Task Team has no opportunity to support countries directly, and it is tempting to conclude that it has outlived its usefulness, but to abolish it now without compensating action in-house might result in an even worse situation (see recommendations in section 6.1).

5.3 Support role played by GAVI HSS technical partners

GAVI HSS technical partners are primarily WHO, UNICEF and World Bank, although in some countries UNFPA and the representatives of some bi-lateral development partners have taken an active part in the GAVI HSS design. Potential advantages of these partners in supporting the GAVI HSS process include their permanent presence in countries, and usually, their good knowledge of the national situation.

Some WHO regional offices have provided worthwhile introductory workshops for countries (supported by GAVI staff or consultants) to familiarise them with the GAVI HSS opportunity and process requirements. Some have gone beyond this and, together with WHO and UNICEF country offices have helped enable country programmes through political lobbying and then through technical support at design and pre-review stages. Most have ceased to play a role once projects have been approved, but generalisations about the specific roles and the relative success with which they have been performed are difficult since there is tremendous variation among regions.

At country level, some WHO staff have strengths in HSS and have made good technical contributions to the design of GAVI HSS proposals and, in a few cases, to their annual review through the APR. But WHO in-country staff do not always have the required skills for HSS or they may not be sufficiently engaged in health sector work or be able to allocate sufficient attention to GAVI HSS related matters.

Moreover, the terms of engagement for technical support are not exposing the adequacy or otherwise of the technical support available. Activities are outlined only in annual work plans (devised by GAVI at global level and not much in evidence on the ground in case study countries), and there is an absence of contractual specification of what exactly is required, what skills are needed, and who exactly is competent to provide it. And these work plans form the basis for transferring GAVI HSS funding. GAVI figures suggest that WHO was paid US\$3,108,350 for HSS work plan support in 2008 (see Volume 2 for details) plus funding of US\$2,521,990 in staff costs, and these are both budgeted to increase for 2009 and 2010. This includes grant money for proposal development (US\$50,000 per country) some of which may be handed on by WHO to consultants appointed by governments (or approved by government if WHO makes the appointment), and a 7% service charge by WHO on the total. Spread over approximately 16 countries preparing applications, this amounts to about US\$352,000 per country per year for technical support almost all of which is for front-end activities. About 75% of this goes to WHO regions, and 25% to WHO HQ. Including similar transfers to UNICEF and World Bank, it amounts to about US\$438,000 per country per year (see Table 5.1).

Table 5.1: GAVI HSS transfers to technical partners US\$

	2008			2009		
	work plan	staff	total	work plan	staff	total
WHO	3,108,350	2,521,990	5,630,340			
UNICEF	363,800	-	363,800			
World Bank	651,000	367,500	1,018,500			
totals	4,123,150	2,889,490	7,012,640	5,455,350	3,147,370	8,602,720
countries applying	16					
\$/country WHO			351,896			
\$/country total			438,290			537,670

Clearly, quite a lot of technical support could be procured for this, hand picked for appropriateness and for the best quality available rather than just because it is there in country (but then the GAVI

would need to develop the capacity to procure it).

5.4 Support role played by Independent Review Committees

Strengths and weaknesses of the IRC proposal assessment and APR review stages have been mentioned earlier and are expanded in Volume 2. The IRCs are not meant or able to provide actual support to countries, and their contribution is very much after the event. They may have limited knowledge of country realities and limited ability to verify data submitted. The individual experience of IRC Members may not always be the most relevant, and there are some comments that the approach can be a bit 'academic' and devoid of practical implementation knowledge. There is no doubt, however, that members invariably work very hard during the evaluation sessions and generally do a good job in the circumstances. In fact, IRC reports suggest that its members are well aware of the limitations of the IRC model, even if this is expressed often not as a criticism of the model but as inability for the IRC to make this or that decision on the basis of available evidence.

6. Recommendations

Altogether, the current GAVI HSS process for technical support to countries for programme design, start up and implementation, and performance review is too 'stand back and then review' and not enough 'engage and help'. Without significant support, many countries do not have the capacity to use GAVI HSS funds effectively and efficiently and to resolve internal tensions in favour of system strengthening rather than the *status quo* of vertical programmes. Current arrangements for technical support are somewhat 'hit and miss' and need more specification and management. Current mechanisms for performance review are weak, and the potential in some countries for serious misuse and leakage of funds requires the need for much tighter accountability and more effective risk-management. This too will be undertaken better through closer engagement throughout the process rather than after the event, or through an external prior review process as planned under the Transparency and Accountability Policy.

At the same time, there are big (upstream) structural problems with public sectors that constrain the delivery of immunisation, MCH and other primary care services, and that work against efficiency and synergy gains possible through full integration. Closer engagement through tailored technical support could help countries draw attention to and act upon these constraints. This will be an essential component of future system strengthening efforts through the proposed GAVI, World Bank and Global Fund Joint Funding Platform.

It cannot be assumed that new moves towards joint assessment of national health plans will obviate the need for more technical support to and engagement with countries at programme design and other key stages. Although joint assessment would be a big step forward in coordination, removing the need for separate appraisals by each funder, and reducing the burden on countries, it does not obviate the need for stronger technical preparation of investments focused on the feasibility of implementing proposed interventions and of measuring their effects on outputs and outcomes. Moreover, since the mandates of the key funding institutions undertaking any joint assessment are to improve disease-specific outcomes, there will still be a need to base funding decisions on programme-specific strategies, and preparation and assessment will still be subject to all the weaknesses identified in this 2009 GAVI HSS evaluation unless changes are put in place to overcome them.

6.1 Recommendations on GAVI capacity to manage the HSS investment process

If GAVI HSS support is to continue - and we argue it should - GAVI must develop in its Secretariat in-house HSS capacity able to:

- Ensure that countries receive the support needed at all stages of the GAVI HSS process. The nature of this will vary greatly from country to country and the GAVI Secretariat must be able to assess this and act upon it.

- Engage more with countries in their design of HSS programmes, including helping them (through targeted technical support) identify opportunities for strengthening upstream processes and mechanisms. Engagement means working more closely with countries, supporting and building capacity, ensuring that planning departments and high-level coordinating bodies are fully involved in a timely way, bringing benchmarks and comparative knowledge, constructively interrogating plans, and ensuring that implementation, monitoring and financial management arrangements are in place or that there is a clear, measurable, priced, step-by-step plan to put them in place as part of the HSS programme. Some of the above needs require a stronger GAVI Secretariat while others rely on its ability to procure the required technical support.
- Develop more practical knowledge of HSS within the Secretariat, in the Alliance and in the countries themselves, and make this available through normal business processes of working with countries. This should be coordinated with the research commissioned by the Bill & Melinda Gates Foundation to improve understanding of what works for routine immunisation.

There are options for GAVI to achieve the above through a combination of strengthening the Secretariat with a small HSS unit, enhancing HSS capacity across other relevant departments, and commissioning external providers perhaps on a call-down contract basis thus minimising the needs for in-house staff growth whilst retaining flexibility to bring in high quality expertise on a competitive basis. The pre-qualified provider would procure experts to support countries as needed at any stage, including in-country assessment of proposals and performance review replacing assessment by IRCs with a process more aligned and built on country monitoring and reporting systems (see section 6.2). Individual experts (who might include WHO or UNICEF staff where they are the best option) would be vetted, contracted, quality assured and paid for via the private sector provider.

The GAVI HSS Task Team should be replaced by a small GAVI HSS Advisory Team, run by and chaired by GAVI, accountable and reporting clearly to GAVI. It should involve GAVI representation at senior level, and members should be primarily selected for their health systems knowledge. Members should represent the interests of GAVI HSS even if they are employed by other organisations. Their role should be:

- to advise GAVI on technical issues on HSS and on the quality of technical support being provided
- to act as a sounding board for GAVI HSS policy and practice
- to ensure that relevant institutions are kept aware of GAVI HSS initiatives and progress
- to provide an opportunity for GAVI to present its ideas and proposals for change to a knowledgeable group prior to finalisation
- to introduce new ideas and proposals into the GAVI internal debate on HSS.

6.2 Recommendations on changes to the GAVI HSS process

GAVI should appraise and manage HSS investments risks more thoroughly, and do this through stronger support to countries, and through assessment at country level.

HSS proposal design

Programme designs should incorporate specific plans for start up and implementation, monitoring and financial management. These are some of the main areas that enhanced technical support should assist with. GAVI should consider how the proposed Financial Management Assessment review can be incorporated into this technical support function, thus obviating the need for building a parallel capacity to undertake that task alone. In addition, through technical support, the GAVI Secretariat should:

- Undertake a more comprehensive assessment of the support needed by an individual country, depending on its planning and implementation capacity, fiduciary risk and robustness of governance structures.
- Use the proposal design process to formalise and promote focus on HSS issues among sector partners and to improve alignment and harmonisation of HSS grants, and to focus HSS grants on underperforming districts and under-served populations, particularly in countries where aggregate DPT3 coverage is already quite high.
- Ensure much more attention is given to the links between the system barriers, the HSS activities and the expected outputs, and that selected HSS indicators can measure systems change outputs and directly related outcomes where possible.

HSS application assessment

As the capacity for engagement outlined above is instituted, application processes should become much more integrated at country level. For this, the GAVI should:

- Undertake grant application assessment in country where proposals can be interrogated and data validated. In practice, this probably means contracting this function to an intermediary able to provide and quality control a team of one or two experts to assess proposals in country, working supportively with country teams to improve programme design, but ultimately responsible for providing an objective assessment to the GAVI Secretariat, and for synthesising lesson learning in the process. Although it is an option, deployment of IRCs at country level would be unwieldy and hugely expensive.
- Ensure that the rounds-based approach used by GAVI for assessing new proposals does not conflict with the need for approval and disbursement of HSS grants to be synchronised with country planning and budgeting cycles. This would require closer engagement between the GAVI Secretariat and the country immediately after approval, at which time the calendar for the most suitable disbursement and reporting dates should be agreed.
- Revise the HSS grant allocation ceiling formula to avoid the sharp transition a country can experience: either base the allocation on GNP at time of application and allow a country to retain that status, or reduce the differential.

A final review of proposals undertaken in house by the proposed HSS unit in the GAVI Secretariat should require little more than checks for consistency with GAVI policy.

HSS implementation and M&E

Stronger HSS technical support will ensure that implementation and M&E responsibilities are spelt out and integrated in proposals. Specifically:

- Where EPI, MCH, or any other departments are responsible for HSS implementation, programme designs should show accountability and reporting links to broader sector planning and coordination structures, to avoid excessive 'projectisation' of HSS grants.
- HSS disbursements –both first disbursement and subsequent annual ones should be aligned with country budgeting and planning cycles.
- HSS M&E should be strengthened throughout by working with countries *now* to improve measurability of the results of investment:
 - In countries with current grants:
 - where countries have functioning data reporting mechanisms (HMIS etc), GAVI Secretariat should provide technical support to ensure that relevant health systems output and outcome data will be generated
 - where countries have relatively undeveloped data reporting mechanisms, GAVI should provide technical support to agree a minimal set of output indicators as proxies for outcomes, and that are realistically measurable with existing system capacity or slightly modified capacity
 - both should include data from appropriate sub-national units to facilitate comparisons with intervention and non-intervention units.
 - In new applications:
 - as part of the enhanced technical support provided to countries during programme design and planning, GAVI Secretariat should ensure that either of the above are agreed and institutionalized as part of the GAVI HSS implementation process.

Annual Review of HSS grants

To improve the performance review process it is recommended that GAVI:

- Adapt the annual review of GAVI HSS grants to the robustness and quality of existing country systems – scenarios for this are discussed in the full evaluation report (Volume 2, section 2.4)
- Replace the fixed-date HSS annual review conducted in Geneva by a process taking place in country, synchronized with the country's planning cycle and using the planning, budgeting and reporting mechanisms of that country by:
 - contracting this function to a private sector intermediary able to provide one or two high quality experts as outlined for HSS grant assessment above (this is seen as a more practical option than convening IRCs in countries and will improve continuity and lesson learning as

long as the provider is required and helped to work closely with both the GAVI Secretariat and the country stakeholders)

- ensuring better links between the assessments done during the design and start up phases and the annual reviews, so that critical issues linked to the HSS proposals remain always in focus and are reported on
- providing countries with technical support to raise the quality of reporting, especially in the first and second years, undertake reviews in step with each country's cycle, and undertake assessment in-house

Some of the changes proposed by this 2009 GAVI HSS evaluation are far reaching, and their implementation may require a delay to new HSS applications until new capacity, processes and management systems are in place.

Annex 1 Authors, team, researchers and key informants

Please note that Case and Desk Studies contain additional names of people approached in each country: our acknowledgements and gratitude to them all.

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DRC, Burundi, Bhutan, IHP+ context
Liberia, Zambia, Nigeria, Sierra Leone
Objective 5, HSS database support
HSS Database, Georgia, Nicaragua, DRC
Objective 4, Cambodia, Nepal, Kyrgyzstan
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Main involvement

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Inception and Final reports
Inception and Final reports
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HSS Task Team (UNICEF)
HSS Task Team (CSO)
HSS Task team (DFID)
HSS Task Team (World Bank)
HSS Task team (Gates Foundation)
HSS Task Team (World Health Organisation)
HSS Task Team (World Health Organisation)
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Thushara Fernando	WHO/SEARO - GAVI Focal Point
Dean Shuey	WHO/WPRO - GAVI Focal Point
Bob Fryatt	IHP+
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Viroj Tangcharoensathien	Advisory Panel to GAVI Secretariat on HSS Evaluation
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¹ Interviewed by Team Leader end of 2008 by phone on HSS APR process

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