Final Synthesis Report

Health Systems Strengthening Tracking Study
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Beth A. Plowman and Wendy B. Abramson

JSI Research & Training Institute, Inc.

InDevelop-IPM

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[1] Please refer to Annex I for a full listing of research institutions and investigators.

ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AHW	Auxiliary Health Worker
APR	Annual Progress Report to the GAVI Alliance
CB – IMCI	Community-based, Integrated Management of Childhood Illness
CHC	Commune Health Center(s) – Vietnam
CHW	Community Health Worker
CHU	Child Health Unit (Zambia)
CJSC	Central Joint Steering Committee
cMYP	Comprehensive Multi-Year Plan for Immunization
CNP	National Steering Committee (Comité National de Pilotage) (DR Congo)
CPR	Contraceptive prevalence rate
CSO	Civil Society Organization
DEP	Department of Studies and Planning (DR Congo)
DFID	Department of International Development (United Kingdom)
DHS	Demographic and Health Survey
DOHS	Department of Health Services
DPH&R	Directorate of Public Health and Research (Zambia)
DPPD	Directorate of Planning and Policy Development (Zambia)
DPT3	Diphtheria-Pertussis-Tetanus Vaccine
DR Congo/DRC	The Democratic Republic of the Congo
DUDBC	Department of Urban Development and Building Construction
EPI	Expanded Program on Immunization
FEDECAME	Regional Warehouse Drug Pooled Procurement and Distribution System (DR Congo)

FMOH	Federal Ministry of Health (Ethiopia)
GAVI	The GAVI Alliance
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GTZ	German Society for Technical Cooperation
HC	Health Center
HCSS	Health Commodity Supply System (Ethiopia)
HEP	Health Extension Program (Ethiopia)
HEWs	Health Extension Worker(s) (Ethiopia)
HMIS	Health Management Information System
HPC	Health Policy Council
HPG	Health Partnership Group
HSCC	Health Sector Coordinating Committee
HSDP-III/HSDP	Health Sector Development Plan (Ethiopia)
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IFI	International Financial Institution
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Newborn and Child Illness
InDevelop-IPM	InDevelop - Institute of Public Management
IP	Interim Plan (DR Congo)
IRC	GAVI Alliance Independent Review Committee
IRT	Integrated Refresher Training (Ethiopia)
ISS	Immunization Services Support
JAR	Joint Annual Review
JCCC	Joint Central Coordinating Committee
JICA	Japan International Cooperation Agency
JSI	JSI Research & Training Institute, Inc.
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MD	Management Division (Nepal)
MDGs	The Millennium Development Goals
MoF	Ministry of Finance
MoHP	Nepal Ministry of Health and Population
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organization
NHSCC	National Health Sector Coordinating Committee (Nepal)
NHSP-IP	National Health Strategic Plan-Interim Plan (DR Congo)
NVG	New Vaccine Grants
OECD/DAC	Organization for Economic Co-operation and Development/Development Assistance Committee
PFSA	Pharmaceutical Fund and Supply Agency (Ethiopia)
PHARMID	Pharmaceutical & Medical Supplies Import & Wholesaler Share
PIU	Program Implementation Unit
PMU	Project Management Unit
PPF-GD	Planning, Program and Finance General Directorate (Ethiopia)
PVO	Private Voluntary Organization
RCI	Republican Center of Immune-prophylaxis
Sida	Swedish International Development Cooperation Agency
SWAp	Sector-wide Approach
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers
TT	Tetanus Toxoid
TWG	Technical Working Group
UNICEF	The United Nations Children's Fund

UNOPS	The United Nations Office for Project Services
USAID	United States Agency for International Development
VHW	Village Health Worker
WHO	The World Health Organization

EXECUTIVE SUMMARY

Launched in 2000, the GAVI Alliance (GAVI) aims to increase immunization coverage and reverse global disparities in access to vaccines. Since its creation, GAVI has helped to increase significantly the number of children worldwide who have access to immunization. The World Health Organization (WHO) estimates indicate that, through GAVI support, a cumulative **51 million** children have been protected with basic vaccines against DPT3 (Diphtheria-Pertussis-Tetanus). Recognizing that system-wide barriers could constrain expanded immunization coverage, the GAVI Alliance Board, in 2005, approved a new window of funding for strengthening health systems (HSS), with support available to all GAVI-eligible countries.

By December 2008, 45 of the 72 countries eligible for GAVI HSS funding had their applications approved. These approved applications have an associated financial commitment of US $532 million. The purpose of GAVI HSS is to address those bottlenecks and system-wide barriers that impede progress in improving and sustaining high immunization coverage and the delivery of other maternal and child health care interventions. This innovative use of funds for HSS makes it possible for recipient countries to address difficult health systems issues such as management and supervision, health information systems, health financing, infrastructure and transportation, health workforce capacity and incentives, public-private partnerships, and involvement of civil society. With this opportunity, however, comes the challenge of monitoring GAVI's investment and learning from past and ongoing proposal and implementation processes so as to continue to improve them.

> Across the board, all six countries uniformly encourage GAVI to continue providing this type of support while also taking steps to improve it.

Since Board approval of the GAVI HSS funding window, plans have been in place for a formal evaluation in 2009 (and again in 2012). However, the GAVI Secretariat and the GAVI HSS Task Team sought an interim assessment of the GAVI HSS application and early implementation experiences, with a focus on how countries are planning, budgeting, implementing and monitoring their programs. In August 2008, GAVI awarded JSI Research & Training Institute, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-Institute of Public Management (InDevelop-IPM), to jointly implement the GAVI HSS Tracking Study.

The Tracking Study was designed to provide real-time evidence regarding the technical, managerial, and policy processes for the successful implementation of GAVI HSS grants in a set of six countries. The Study's three objectives were (1) improving the quality of project design/applications and strengthening implementation; (2) developing responsibility and ownership over the monitoring of GAVI HSS and promoting its integration into ongoing processes at the country level; and (3) establishing a network of countries implementing GAVI HSS—beginning with the countries in the case studies—and facilitating cross-country learning and capacity building among them. A detailed description of Tracking Study approaches, methods and planned activities can be found in the Inception Report (JSI and InDevelop-IPM, 17 October 2008). Preliminary findings are available in the Phase 1 Synthesis Report (JSI and InDevelop-IPM, 4 February 2009).

Based on a set of objective criteria[2] and the input of the GAVI HSS Task Team, six countries were chosen as case studies: Ethiopia, the Democratic Republic of the Congo (DR Congo), Kyrgyz Republic, Nepal, Vietnam and Zambia. These countries were selected with purposive sampling in order to reflect a broad range of country settings and experiences. The grants in these six countries account for 20 percent of the total Board commitments of US $800 million for GAVI HSS funding. A significant variable for the conduct of the Tracking Study was the duration of grant implementation—considered here as the number of months from the first disbursement to July 2009, when each country held an in-country workshop to review draft case studies generated from this research. On average, 21 months had passed since each country received its first tranche of GAVI HSS funds.

The end product of this work includes six country case studies, a Multi-Country Workshop held in Stockholm, Sweden, 15-17 September 2009 and this Final Synthesis Report.

The Tracking Study was implemented through a three-phased approach. Phase 1 encompassed the inception period which included work plan and timeline revisions, identification of key questions, tools and methods development, and piloting of the study tools. Initial country assessment visits were made to all six study countries, during which key informant interviews were conducted, documents reviewed, local research partners identified and country-specific study planning initiated. The second phase of the Tracking Study was carried out by experienced local research and training institutions, including universities (DR Congo, Vietnam and Zambia) as well as private-sector organizations with extensive public health research expertise (Ethiopia, Kyrgyz Republic and Nepal). Country research teams were supported by an international country coordinator from either JSI or InDevelop-IPM.

Each country built on a core set of study approaches, guidelines and tools, adapting and expanding them to fit the country setting and characteristics of the grant. In general, three types of methods were included in the Phase 2 data collection: interviews, document review, and observation. The Study Team generated an evidence base by documenting and describing (1) the management, coordination and financial mechanisms which support HSS implementation at central and sub-national levels; and (2) the status of implementation, with particular focus on the performance indicators included in the application for GAVI HSS funds.

In each country, a purposive sample of program areas was selected for field visits and data collection. Typically, research teams would proceed in stepwise fashion, visiting the first sub-national level (e.g., region, province) and then proceeding to a selected set of second sub-national level sites (e.g., district, health zones), followed by visits to health facilities for interviews with service providers (e.g., officers in charge, midwives). Field work was conducted, typically in multiple rounds, between the months of February and May 2009. On average, over 50 individuals were interviewed in each country, including regional- and district-level health program managers; planning, surveillance and immunization officers; health center officers; and clinical staff. Program documentation, including expenditure reports, were also collected across levels and reviewed.

The Tracking Study sought to strengthen in-country capacity to monitor GAVI HSS through the active engagement of local research organizations with the Ministry of Health (MoH) and partners responsible for HSS management, oversight and coordination. Country workshops were an important element in

[2] Variables in the selection included HSS commitments, disbursements, rounds, approval dates, HSS proposal themes, economic status, birth cohort, JSI/InDevelop-IPM presence in countries, country links to networks, and involvement in other related global initiatives/programs.

that implementers and stakeholders across both national and sub-national levels were brought together to dialogue on the status of implementation and bottlenecks encountered. Representatives from MoHs who participated in the Multi-Country Workshop reported that the findings and conclusions of the Tracking Study were useful to their work, notably in (a) identifying areas of strengths and weaknesses in implementation, and (b) planning for future sector strategies and applications for GAVI or other HSS funding.

Phase 2 focused on country start-up and performance during implementation of GAVI HSS-funded work plans. Performance was defined as progress within specific activity or component areas with reference to stated indicators and targets. A challenge encountered has been in discussing and comparing implementation performance across grants that vary significantly in both scale and scope. Using these parameters, performance in one country might be measured against the drilling of 47 boreholes while in another it is the launching of a nation-wide health commodity supply system—from policies and manuals to construction of warehouses. In assessing GAVI HSS implementation, a set of factors and themes were identified which define the context for implementation and may serve to either drive or hinder performance. Those factors and key findings include:

Planning, management and coordination

- Within the Tracking Study countries, responsibility for the management of the GAVI HSS-funded activities varies in regard to its institutional placement, reliance on existing government structures and human resources assigned. To date, these management arrangements vary in their ability to meet the needs of GAVI HSS implementation.

Financial flows

- As with the management arrangements above, countries chose a number of differing financial mechanisms to channel the GAVI HSS funds into the country. These financial mechanisms are seen to affect the speed of implementation.
- Most countries consider their GAVI HSS funds to be "on-budget," although a variety of pooled and special account mechanisms are being used.
- Several countries with Sector-wide Approaches (SWAps) and pooled funding mechanisms chose to channel GAVI HSS funds through separate, non-pooled accounts. Countries cite the need to link their GAVI HSS spending to specific activities and to report on the results of those activities as one of the principal barriers to including these funds in their pooled funding mechanisms.
- In four of the six countries, more than 50 percent of GAVI HSS funds are designated for central-level procurement of goods and services, which are used and/or delivered at the sub-national level.
- Several countries have relied on development partners with well-established mechanisms and procedures to "jump start" the large-scale procurement of goods and services. The challenge in this situation is striking a balance between efficiency of implementation and building the capacity of national institutions.

HSS monitoring and evaluation

- There is insufficient attention to collecting and analyzing output-level measures—which reflect tangible changes in service availability, accessibility and quality that result from the types of investments made with GAVI HSS funding (i.e., human resources for health; supplies, equipment and infrastructure; and management and organization). This gap results in an inability to fully describe the sequence of activities, interim (outputs) and longer-term results (outcomes/impacts) as was intended in the GAVI HSS framework.

Technical support

In general, the Tracking Study countries rely on longer-term, locally available sources of technical support rather than on acquiring short-term external assistance. Civil Society Organizations (CSOs) and Non-Governmental Organizations (NGOs) are engaged, often through contracts, to implement GAVI HSS activities. Their role in implementation differs from that in the GAVI HSS proposal development processes, where little direct involvement of these groups was reported.

The Tracking Study identified bottlenecks to implementation, including:

- Basic structures and mechanisms that indicate a country's "readiness to implement" are not in place when disbursements begin.
- The amount of time required for pre-implementation preparatory activities, including procurement, is significantly underestimated.
- GAVI HSS funds' arrival "off-cycle" with national fiscal year planning creates delays in funds disbursement from national to sub-national levels, subsequently creating problems with full utilization and expenditure reporting within the given time frame.
- The cost of commodities is under-estimated, resulting in target modification.

It is important to highlight that many of the gaps in implementation observed by the Study Team are not specific to GAVI HSS funding; rather, they pertain more broadly to the implementation of the countries' national health sector strategies and HSS efforts in general. Therefore, it is important to review the GAVI HSS implementation status described in this study in light of the overall performance of the health sector and commonly encountered obstacles to implementation.

The Tracking Study's conclusions and recommendations are based upon information gathered through primary data collection in the six Tracking Study countries. Recommendations were discussed and adjusted by the Tracking Study team and participants of the six countries, including local research teams and government officials, during the three-day Multi-Country Workshop held in Stockholm, 15-17 September 2009. Recommendations and the associated conclusions are tabulated below.

	Conclusions	***Recommendations***
1.	**Countries value the multi-year, flexible, country-driven characteristics of GAVI HSS grant funding. Across the board, all six countries uniformly encourage GAVI to continue providing this type of support while also taking steps to improve upon it.**	• *The GAVI Alliance should continue with their HSS grants with the same principles and in much the same form with improvements based on experience to date. Other global actors might consider following suit.* • *The GAVI Alliance should increase its alignment with national planning and budgeting cycles, harmonize its reporting requirements with those of other donors, ensure more consistent communication with countries and stakeholders (particularly about GAVI HSS applications and review processes), and increase its own involvement in coordination mechanisms such as Joint Annual Reviews at the country level.*

	Conclusions	*Recommendations*
2.	**Aligning GAVI HSS with health sector plans and processes facilitates start-up, implementation and monitoring and evaluation.**	• *The GAVI policy to align HSS grants with national health plans has a positive effect on implementation and should continue to be required and strengthened where possible.* • *Situational assessments should include and/or further examine the country's capacity to both financially and programmatically implement HSS funding prior to preparation of a GAVI HSS proposal ("readiness to implement"). If this has not been done prior to proposal submission, then a situational assessment of readiness to implement must be conducted upon approval of the grant but prior to disbursement of funds.*
3.	**The management models employed across the six countries varied in their ability to meet the needs of HSS implementation. However, in only one case was management a major impediment to implementation.**	
4.	**High-level leadership and health sector coordination, while important for successful application and design, are not sufficient.**	• *The GAVI's "light touch" model may be less appropriate for HSS grants than for Immunization Services Support (ISS) and New Vaccine Grants (NVGs). The GAVI Alliance should strongly consider more active engagement with country-level partners around core health systems dialogue and assessment (e.g., Joint Annual Reviews).* • *Ministries of Health (MoHs) should make more concerted efforts to inform and engage stakeholders outside the central MoH in the planning and implementation of GAVI HSS, including NGOs/CSOs and sub-national health offices.* • *The GAVI Alliance should recognize the gap between its stated principle (i.e., Government entities, partners, civil society, and the private sector should all be informed and involved, as appropriate, in the planning, implementation and evaluation stages) and practice in countries. At a minimum, the GAVI Alliance and its partners in-country should inform and engage stakeholders outside the central MoH and encourage their involvement in the planning and design of GAVI HSS applications. Creating awareness about GAVI HSS would ensure greater transparency and accountability.* • *Ministries of Health, the GAVI Alliance and their in-country partners, and all multilateral and bilateral partners working in HSS should encourage NGOs/CSOs to be proactive in the health sector development process.*
5.	**NGOs/CSOs are implementing specific GAVI HSS-funded activities in several countries and helping to speed up implementation, but they are not involved in GAVI HSS design or oversight.**	
6.	**Substantial delays in implementation are experienced when the necessary financial systems/arrangements are not in place at the time of GAVI Alliance approval.**	• *GAVI should verify that accountable and transparent fiduciary and financial management systems, not just bank accounts, are in place before disbursing significant amounts of GAVI HSS funding to a country.* • *Countries that will need to put financial management units in place or to strengthen financial management systems prior to receiving disbursements of funds for*

	Conclusions	*Recommendations*
		HSS implementation should establish realistic timelines for their implementation plans. • *Where financial systems/units are not already established and functioning, GAVI should modify its business model to allow for a two-phased approach: in phase 1, GAVI would support the establishment of a mechanism for financial management and accountability, and in phase 2, the focus would shift to actual implementation.*
7.	**GAVI's review, approval and disbursement cycle is out of sync with the annual planning and budgeting cycles in many countries. Alignment of GAVI's disbursement of funds with the planning and budgeting cycles of the individual countries would facilitate efficient spending of resources.**	• *The GAVI application/proposal submission, approval, and disbursement processes should be better aligned and synchronized with country planning and budgeting cycles and with fiscal year requirements in order to avoid delays and thereby strengthen the predictability of the arrival of funding.* • *Countries should be fully and routinely informed about the expected duration of proposal submission, IRC review, board approvals and disbursements so that they can plan more effectively for the actual receipt and use of funds.* • *GAVI Alliance participation in country coordination processes should be strengthened with the intention of formally entering into pooled funding mechanisms, participating in the Joint Annual Review meetings that are now a feature in many countries, and improving communications with countries and stakeholders about the GAVI HSS funding window and its requirements.*
8.	**Country Monitoring and Evaluation (M&E) plans in HSS applications often include appropriate input and outcome indicators, but they generally lack output indicators as well as the means to measure such indicators on a regular basis.**	• *GAVI and other partners should work with governments to harmonize their M&E requirements, align them with country-specific indicators and agree on a common reporting format and frequency to reduce the burden on countries.* • *The GAVI Alliance should continue to provide funding through the GAVI HSS grants to strengthen health management information systems.* • *GAVI should strongly encourage countries to define appropriate HSS indicators and to more fully substantiate indicator definitions, data collection mechanisms and frequency of collection in the application.* • *GAVI should recognize that few countries will submit a fully operational M&E plan in the application and consider a two-stage approach to country M&E planning, with the first step being submission and approval of an illustrative M&E plan with the GAVI HSS application and the second being development of a final M&E plan—detailing indicators, methods, processes and costs—after the application is approved. GAVI, along with other global actors in HSS funding, should provide technical assistance to the*

	Conclusions	*Recommendations*
		countries if required. • *GAVI should participate in multi-partner Joint Annual Review processes in countries and accept the reports from these reviews in place of a separate annual reporting requirement.*
9.	**There have been multiple revisions of the GAVI HSS application guidelines and some inconsistencies in messages between the GAVI Alliance and some of the GAVI HSS-recipient countries, including criteria for Independent Review Committee (IRC) review of applications.**	• *GAVI should provide clear and consistent guidelines to countries on how GAVI HSS may be spent, including re-allocation/re-programming of funds and use of funding for recurrent costs such as salaries.* • *GAVI IRC decisions should be based on objective criteria, a proposal checklist and a scoring system that can then be shared with the country.* • *GAVI should provide more guidance on how the GAVI HSS principles can be made operational. Clarify what, if any, role those principles will play in the evaluation of GAVI HSS funding.* • *GAVI IRC feedback on proposals should be more substantial, with clear explanations as to where and how proposal elements fall short as well as to how to improve upon them.*
10.	**Frequently, countries underestimate the time needed to prepare for grant implementation, including the time needed for curriculum development for training activities, establishment of procurement mechanisms and agreements.**	• *Countries should assess risks and more accurately estimate timelines for pre-implementation start-up activities, such as curriculum development and establishment of procurement procedures and mechanisms, in proposal development during GAVI HSS start-up and build their timelines accordingly.* • *GAVI and other stakeholders should encourage countries to continue striking a balance between efficiency (contracting out for procurement) and using GAVI HSS to build their ministries' own procurement capacity (managing GAVI HSS-related procurement directly).*
11.	**Countries are using a variety of procurement mechanisms and agents—both governmental and non-governmental—to accelerate the implementation of GAVI HSS.**	
12.	**Countries tap into a wide range of technical assistance options that are not always reflected in discussions at the global level.**	• *GAVI should broaden its definition of technical support to be more in line with country definitions and use.* • *Countries should periodically update their technical support needs/plans throughout the life cycle of the grant and take steps to access either local or external technical expertise if needed. For example, joint annual review processes can serve as an opportunity to identify barriers to implementation and any associated technical assistance needs.* • *The GAVI Alliance should encourage countries to seek technical support in areas that the Tracking Study identified as weaknesses and implementation bottlenecks, notably HSS monitoring and evaluation and financial management systems.*
13.	**There is a demand from countries for more information about experiences and lessons learned by other GAVI HSS recipient**	• *The GAVI Alliance should strengthen its mechanisms for information sharing and dissemination of experiences in HSS application, implementation and*

	Conclusions	*Recommendations*
	countries.	*M&E.* • *A range of mechanisms for engagement and information sharing should be examined. For the early years of GAVI HSS implementation, it may be necessary to convene physical meetings to help germinate a "community of practice" around these issues.*
14.	**GAVI HSS can be an important catalyst for the creation and/or use of pooled funding mechanisms. At the same time, GAVI HSS is not always a good fit because the regulations governing pooled funding and GAVI's own requirements make pooling difficult for some countries.**	• *The GAVI Alliance should recognize the gap between its stated principle (i.e., HSS support should be in line with government management systems and financial management procedures) and the practical obstacles that prevent countries from doing so. In the context of pooled funding mechanisms, clarification of GAVI's need to have HSS-fund specific financial and results reporting is required.* • *The GAVI Alliance, together with donors and other in-country stakeholders, should work together to negotiate and contribute to the country's health sector development to fill gaps instead of duplicating, causing system fragmentation and disrupting on-going efforts.*

GAVI and other major HSS contributors (i.e., The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank) are discussing a joint platform in order to provide more coordinated and effective HSS support to countries. In these discussions, it is important that the very positive attributes of GAVI HSS support are maintained and expanded to the extent possible. Foremost among these attributes are flexibility, country-led proposals and implementation, alignment with national health priorities and rapid disbursement of funds. At the same time, the Tracking Study has identified a number of areas where GAVI can improve its provision of HSS assistance. These lessons should also be carried forward in the design of a joint platform. Further, it would be conducive if steps were taken to assess, on an on-going basis, the progress being made to improve these areas needing attention. This form of assessment will be beneficial not only to GAVI but to its partners in the joint platform as well. The tools and materials developed for use in the Tracking Study may well serve this process.

I. Introduction

A. GAVI HSS background

The GAVI Alliance was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. Governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, Non-Governmental Organizations (NGOs), foundations, vaccine manufacturers, and public health and research institutions work together as partners in the Alliance to achieve common immunization goals. All members of the Alliance recognize that only through a strong and united effort can much higher levels of support for global immunization be generated.

Health system strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. Based on analytical work that examined system-wide barriers to expanded immunization coverage, in late 2005 the GAVI Alliance Board made new HSS support available to all GAVI-eligible countries. Currently, US $800 million is available from GAVI for HSS to help countries overcome system-wide barriers that constrain productivity and progress in providing immunization and other child and maternal health (MCH) services. By December 2008, 45 of the 72 countries eligible for GAVI HSS funding had their applications approved. These approved HSS applications have an associated financial commitment of US $532 million.

The purpose of GAVI HSS is to address those bottlenecks and system-wide barriers that impede progress in improving and sustaining high immunization coverage and the delivery of other maternal and child health care interventions. This innovative and potentially catalytic use of funds for health system strengthening makes it possible for recipient countries to address difficult health system issues such as management and supervision, health information systems, health financing, infrastructure and transportation, health workforce capacity and incentives, and public-private partnerships and involvement of civil society. With this opportunity, however, comes the challenge of monitoring GAVI's investment and learning from past and ongoing proposal and implementation processes so as to continue to improve them.

In the several years since GAVI began offering funds to strengthen health systems, an international dialogue has ensued on the role of global health initiatives in providing such support to achieve lasting improvements in health outcomes. Notable among these momentum-building efforts are the study of the Maximizing Positive Synergies Collaborative Group[3], convened by WHO, and deliberations of the High Level Dialogue and its Venice statement on global health initiatives and health systems[4,5]. For GAVI, this dynamic environment is best illustrated by recent discussion and conceptualization of a joint mechanism to harmonize GAVI, GFATM and the World Bank health systems funding to improve its efficiency and effectiveness[6,7]. In endorsing these steps, the GAVI Alliance Board has requested a set of

[3] World Health Organization Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. Lancet 2009; 373: 2137–69.

[4] Horton R. Venice statement: global health initiatives and health systems. Lancet 2009; 374: 10-12.

[5] Atun R, Dybul M, Evans T, Kim, Jim Yong e, Moatti, J-P, Nishtar, S, Russell A. Venice Statement on global health initiatives and health systems. Lancet 2009, 374: Issue 9692:783-784.

[6] The subject of a Technical Workshop on Health System Strengthening convened by the World Bank (Health Nutrition, and Population [HNP], World Bank Institute [WBI], Health Systems Global Expert Team [HSGET]), the GAVI Alliance and The Global Fund to Fight AIDS, Tuberculosis, and Malaria [Global Fund]),in Washington D.C. from 25-27 June. Workshop materials can be found at http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/

[7] GAVI Secretariat. Toward harmonised health systems funding (FOR GUIDANCE). GAVI Alliance Board – 2-3 June 2009.

decision options for GAVI involvement in health system funding and for harmonizing health system funding at the November 2009 Board meeting[8].

B. The GAVI HSS tracking study overview

The inter-agency HSS Task Team and the GAVI Secretariat sought an interim assessment of GAVI HSS applications and early implementation experience with a focus on how countries are planning, budgeting, implementing and monitoring their programs. To that end, the GAVI HSS Tracking Study was developed and launched in 2008. Two analytical efforts were developed to assess the GAVI HSS investment in a complementary manner: the GAVI HSS Tracking Study and a formal evaluation commissioned and conducted in 2009. As noted recently by the GAVI Alliance Board, the findings of the GAVI HSS Tracking Study and the GAVI HSS Mid-term Evaluation are intended to help guide GAVI's future investment in health systems and decisions about harmonization efforts.

GAVI sought external assistance to conduct the Tracking Study and, in August 2008, awarded JSI Research & Training Institute, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-Institute of Public Management (InDevelop-IPM), to jointly implement the Tracking Study. Working closely with the GAVI Secretariat, the GAVI HSS Task Team and the Study's Steering Committee, the JSI/InDevelop-IPM team launched the GAVI HSS Tracking Study with a goal of completing, in 13 months, implementation-level GAVI HSS tracking and producing case studies in six HSS-recipient countries.

The study team designed its activities to meet the study's three objectives as laid out in the Terms of Reference, as follows:

- Primary: Improve the quality of project design/applications and strengthen implementation.
- Secondary: Develop responsibility and ownership over the monitoring of GAVI HSS and promote its integration into ongoing processes at the country level.
- Tertiary: Establish a network of countries implementing GAVI HSS—beginning with the countries in the case studies—and facilitate cross-country learning and capacity building among them.

The study team saw these objectives as inter-linked, with all three acting synergistically toward sustainable improvements in the GAVI HSS proposal and implementation processes. Accordingly, the Tracking Study was designed to provide real-time evidence from the country level regarding the technical and managerial processes for implementation of GAVI HSS grants. The end products of the Tracking Study include this Multi-country Synthesis Report, a set of six country case studies, and a Multi-Country Workshop, conducted in Stockholm, Sweden from 15-17 September 2009.

C. Country characteristics

During the inception period, criteria were developed and applied[9] for the selection of study countries. A proposed set of countries was presented to the GAVI HSS Task Team for consideration. Based on Task

[8] http://www.gavialliance.org/about/governance/boards/reports/2009_06_02_allianceboardmeeting.php.

Team input, six countries were chosen: Ethiopia, the Democratic Republic of the Congo (DR Congo), Kyrgyz Republic, Nepal, Vietnam and Zambia.

The grants in these six countries account for 20 percent of the total Board commitments of US $800 million for GAVI HSS funding. These countries were selected with purposive sampling in order to reflect a broad range of country settings and experiences. As seen in Table I.1, these countries capture a wide range of maternal and child health conditions and health systems. Among them are three African countries (Ethiopia, DR Congo and Zambia) with high levels of mortality and fertility and a heavy reliance on external funding for the health sector. Countries included from the Central Asia and Asian regions were characterized by far lower levels of mortality and fertility, higher per capita expenditures on health, and less reliance on external sources of funding for the health sector.

Table I.1. GAVI HSS Tracking Study - Maternal and Child Health and Health Systems Indicators

	Ethiopia	DR Congo	Kyrgyz Rep.	Nepal	Vietnam	Zambia
Maternal and child health						
Under-five mortality rate	204	161	38	55	15	170
Live births	3,201,000	3,118,000	115,000	796,000	1,653,000	473,000
TFR	5.3	6.7	2.5	3.3	2.2	5.2
DPT3 coverage rate	81%	69%	95%	82%	93%	80%
% of districts with DPT3 coverage ≥ 80 %	46%	54%	100%	44%	97%	76%
Health systems						
GNI per capita (US dollars)	$220	$140	$590	$340	$790	$800
Per capita total expenditure on health (avg. exchange rates in US dollars)	$7	$6	$34	$17	$46	$49
External resources for health as a % of total expenditure on health	43	29	6	16	2	37
Nursing/midwifery personnel (per 10,000 pop.)	2	5	58	5	8	20

Sources: Maternal and child health indicators and GNI per capita are drawn from UNICEF http://www.childinfo.org/statsbycountry.html. For DPT3 and district coverage: http://www.who.int/vaccines/globalsummary/immunization/countryprofileresult.cfm. Health systems indicators: WHO www.who.int/whosis.

[9] Variables included in the selection are HSS commitments, disbursements, rounds, approval dates, HSS proposal themes, economic status, birth cohort, JSI/InDevelop-IPM presence in countries, country links to networks and involvement in other related global initiatives/programs.

The countries vary substantially in the scale and nature of their GAVI HSS grants (Table I.2). Total grant amounts, dependent on criteria including Gross National Income (GNI) per capita and size of the birth cohort, vary from US $1.15 million in the Kyrgyz Republic to US $76 million in Ethiopia. The duration of grants is roughly similar as the GAVI HSS window only opened in 2006, and grants had to coincide with the remainder of each country's national health strategy (which was 2010 in all cases). This set of countries also varied according to their strategy in directing resources to populations in greatest need and to low-performing areas. Five of the six countries targeted the GAVI HSS resources to low-performing areas using indicator-based analyses. In some cases, entire provinces or districts were selected based on their performance (DR Congo, Vietnam and Zambia). In other cases, specific activities were targeted at certain areas of the country (Kyrgyz Republic and Nepal). Only Ethiopia sought to reach all geographic areas in the country with funds allocated through an existing equity formula used to determine regional resource allocation.

Table I.2. GAVI HSS Tracking Study, GAVI HSS Grant Characteristics

	Ethiopia	DR Congo	Kyrgyz Rep.	Nepal	Vietnam	Zambia
GAVI HSS grant amount (US $, millions)	$76.49	$56.81	$ 1.15	$ 8.66	$16.28	$6.6
Duration	2006-2010	2007-2010	2007-2008	2008-2010	2007-2010	2007-2010
Targeting	By equity formula	65 of 515 health zones	By activity	By activity	10 of 64 provinces	12 of 72 districts
Months since 1st disbursement	27	17	23	15	23	21

A significant variable for the conduct of the Tracking Study was the duration of grant implementation—presented here as the number of months from the first disbursement to July 2009, when each country held an in-country workshop to review draft Case Studies. On average, 21 months had passed since the countries received their first tranche of GAVI HSS funds.

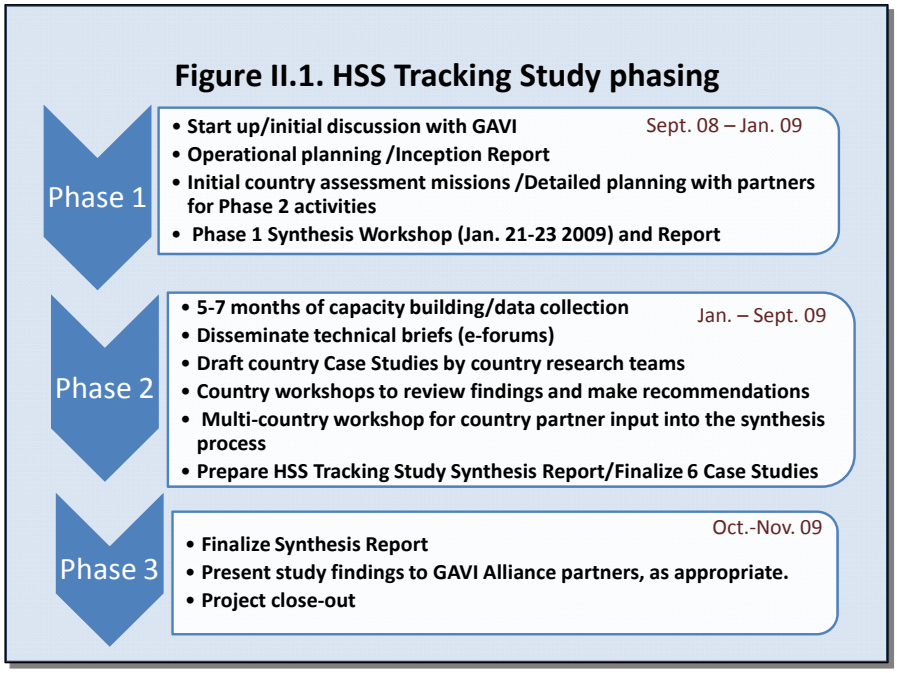
This Final Synthesis Report is structured as follows: In Section II, the methods used for the Tracking Study in two distinct phases are summarized. In Section III, country-specific implementation against targets is assessed. In Section IV, a series of synthesis themes are presented with the team's findings, along with evidence for each theme. Recommendations drawn from the work are presented in Section V. It is important to note that this Synthesis Report is a companion piece to the six individual Country Case Studies. Those reports provide much more detail on all of the issues and themes addressed here in a summary fashion.

II. Methodology

A. Phased approach

The Tracking Study was implemented through a three-phased approach (see Figure II.1). Phase 1 encompassed the inception period with work plan and timeline revisions, identification of key questions, tools and methods development, and a piloting of the study tools in one country (Zambia).

Figure II.1. HSS Tracking Study phasing



The Study tools were designed to ensure that a common set of main themes were explored across countries (Table II.1). To fulfill this aim, the Tracking Study collected and analyzed both qualitative and quantitative information. A common set of study approaches, guidelines and steps were developed to ensure consistent application across countries.

Table II.1 Main Themes Explored in GAVI HSS Tracking Study

GAVI HSS application process
• Chronology of GAVI HSS application • Coordination and decision-making in proposal development • Stakeholder perceptions of proposal development process
GAVI HSS application content
• Brief description of country's GAVI HSS approach • Monitoring and evaluation plan • Attention to the Paris Declaration and GAVI HSS principles • Summary of strengths and weaknesses
GAVI HSS implementation experience/absorptive capacity
• Management and coordination mechanisms • Attention during implementation to GAVI HSS principles • Financial management and flow of funds • Monitoring and evaluation practices • Country performance against plans and targets

Initial country assessment visits were made to all study countries, during which key informant interviews were conducted, documents reviewed, local research partners identified and country-specific study planning initiated. Finally, a partial draft of each country case study was prepared, synthesis themes were identified and discussed in a three-day Study Team workshop, and a Phase 1 Synthesis Report was prepared.

As part of the initial country visit, activities for Phase 2 were

discussed with stakeholders. This phase of the Tracking Study was carried out by experienced research and training institutions within each country that worked under sub-contract with either JSI or InDevelop-IPM. Local institutions included universities (DR Congo, Vietnam and Zambia) as well as private sector organizations with extensive public health expertise (Ethiopia, Kyrgyz Republic and Nepal). Country research team members appear in Annex I. Each country research team was supported by an international country coordinator from either JSI or InDevelop-IPM.

Phase 2 activities were focused on data collection and engagement of country stakeholders on issues surrounding GAVI HSS implementation, including monitoring. In general, Study Team members initiated the discussion of Phase 2 with the GAVI Focal Point by focusing on the performance indicators included in the GAVI HSS application. The Study Team sought to build on existing monitoring and supervisory approaches and to avoid parallel efforts and added burdens on implementers. Each country adapted tools and methods developed by the core study team leaders to fit the country setting and characteristics of the grant, selected sub-national units on a purposive basis, and conducted field visits for the purposes of interviews, document review and observations. Field work was conducted, typically in multiple rounds, between the months of February and May 2009. Summary description of the main methods appears below, and more detailed descriptions of the methods used in each country can be found in Annex II.

Key informant interviews: Key informant interviews were targeted during two phases of the project. During the first phase of the Study in each country, interviews were conducted at the central level (in national capitals) with individuals who were involved in GAVI HSS applications; those responsible for GAVI HSS management, coordination and/or implementation; those with specialized knowledge (e.g., Monitoring & Evaluation (M&E) systems or financial management); and those knowledgeable about HSS priorities, challenges and activities within the country, including other donor efforts. In this phase, on average, 21 individuals were interviewed in each country. In Phase 2, interviews where aimed primarily at program managers and service providers at sub-national levels. These structured interviews included regional- and district-level health program managers; planning, surveillance and immunization officers; health center officers; and clinical staff. In addition, several countries conducted group interviews with neighborhood health associations and volunteers. On average, over 50 health professionals were interviewed across sub-national levels.

A summary of key informants by country and organizational type appears in Table II.2. A complete list of individuals interviewed appears in Annex III.

Table II.2 GAVI HSS Tracking Study: Key Informant Interviews Summarized by Type

	Respondent type	Ethiopia	Kyrgyz Republic	DR Congo	Vietnam	Zambia	Nepal
Phase 1	MOH-Planning	2	3	1	8	2	1
	MOH-other	4	3	8	3	5	9
	Other min./gov't agency		8	1	4		2
	Multilateral agencies	9	3	10	2	6	5
	Bilateral donors	4		6	1		3
	NGOs/PVOs	1	3	1			1
	TA providers	2	1	2	1	3	1
	TOTAL	22	21	29	19	16	22
Phase 2	1st sub-ntl. level (e.g., region, province)	10	12	31	12	6	3
	2st sub-ntl. level (e.g., district, health zones)	9	5	68	13	19	5
	Service providers (e.g., Offices in Charge, mid-wives)	24	34	58	15	16	
	Community and volunteers		✓		✓	✓	
	Total	43	51	157	40	41	8

Document review: Country research teams were provided with a standardized document review protocol, including the study questions answerable through existing documentation, reference to an appropriate document set (per question) and recommended formats for summarizing select variables. A core set of documents were available to all country research teams through a JSI-maintained web-based shared project site. Where possible, expenditure data from sub-national levels was tabulated and analyzed. A summary of the type of documents included in the review appears in Table II.3.

Table II.3 GAVI HSS Tracking Study Document Review Materials

- Country GAVI HSS application/proposal
- Comp. Multi-Year Plan for Imm. (cMYP)
- National Health Sector Plan or equivalent
- Health Sector Reviews and Assessments
- Poverty Reduction Strategy Paper (PRSP)
- As relevant and available:
  - World Bank health sector support docs
  - GFATM proposals with HSS element
  - Studies of system-wide effects (AIDS)
  - HMN HMIS assessments
  - other donor initiative documents
- Recent Household surveys, WHO surveillance website, other sources of key indicator data
- IRC comments on GAVI HSS proposal
- Annual Progress Reports to GAVI (APR) and review of IRC/Monitoring
- Minutes of the HSCC, ICC
- National HMIS reports/datasets
- MoH financial reports
- Annual work plans and budgets
- Regional and district expenditure reports
- Program plan and implementation documents
- Monitoring and supervision systems and tools
- Training materials
- Facility records

Observation of field work: In several countries, the Tracking Study field work included observation. The use of this method was tailored to the nature of the GAVI HSS-funded activities and included health facility checklists (Ethiopia and Zambia) and training observation (Nepal).

In the third phase, Tracking Study activities drew to a close with the review and finalization of this Report.

Limitations of the Tracking Study methods include duration of the study and heavy reliance on interviews as a data source. To track implementation of the HSS grants, it would have been beneficial to have had a longer time-frame. In practical terms, the six country study teams were able to provide a "snap shot" of actual implementation during a four-month window (February-May 2009). Ideally, repeat observations, using a sub-set of study tools, would be carried out at least two more times to provide a more rigorous assessment of implementation over time. In addition, the extensive use of information from interviews is a potential limitation. Many interviewees are implementers of the GAVI HSS-funded activities and may have an interest in presenting progress in the best possible light. The Study Team found that by interviewing across levels (e.g., central level MoH staff, regional- and district-level program managers as well as health center staff) a more in-depth and balanced view of implementation and bottlenecks emerged.

B. Capacity building objective of the tracking study

The Tracking Study sought to strengthen in-country capacities to monitor HSS through the active engagement of local research organizations, with the MoH and partners responsible for HSS management, oversight and coordination. Each country team prepared a Case Study and held a country workshop for key informants and stakeholders across both national and sub-national levels to discuss the status of implementation and bottlenecks encountered.

Phase 2 culminated in a Multi-country Workshop held in Stockholm, Sweden from 15-17 September 2009. In the Multi-Country Workshop, each country had the opportunity to present the findings of their work; discuss issues, experiences and synthesis themes with other country participants; and respond to questions and clarifications from the Steering Committee and GAVI Secretariat. These exchanges were rich and detailed, and brought to the forefront areas of important convergence and divergence. Participants cited the Workshop as a valuable opportunity to learn from others how proposals were developed, gain ideas for improving implementation, and obtain feedback and clarification from the GAVI Alliance. In the self-assessment, respondents were unanimous that the Tracking Study overall had facilitated cross-country learning and capacity-building.

The discussions during the Multi-Country Workshop contributed directly to the drafting of the Final Synthesis Report. Comments and input on the report were provided by an inter-agency Steering Committee facilitated by the GAVI Alliance Secretariat.

To assess the extent to which Tracking Study objectives were met, the Study Team requested participants at the Multi-Country Workshop to complete a confidential, written self-assessment exercise. All representatives from the Ministries of Health (MoHs) reported that the findings and conclusions of the Tracking Study were indeed useful to their work, notably in (a) identifying areas of strengths and weaknesses in implementation and (b) planning for future sector strategies and applications for GAVI or other HSS funding. Both MoH and research organizations strongly agreed that the Tracking Study had helped to strengthen and focus M&E for GAVI HSS in their countries. Several MoH participants felt that the Tracking Study could have been even more useful, with greater levels of

collaboration between the MoH and the research teams during study implementation. Respondents were unanimous in the view that the Tracking Study increased the knowledge of the research organizations in regard to HSS efforts within the country. Opinion was divided as to whether the Tracking Study increased knowledge of study methods, given that the organizations recruited were experienced in research. Ministry respondents saw further opportunity to enlist the research organizations in health system assessments as their HSS-specific understanding and knowledge had been enhanced.

It is important to highlight the participatory and country-driven nature of the Tracking Study, both in terms of data collection as well as analysis, interpretation of data and conclusions and recommendations. As mentioned previously, although the methodology and tools used for data collection were developed by the Tracking Study's international team, each country research organization adapted the methodology and tools to suit the country context and needs. The data contained in the six country case studies is presented from the country perspective and is rich in lessons learned not only for the GAVI Alliance but for Global Health Partners working in HSS in the field.

III. Findings – Implementation Experience

GAVI recognizes that preparation of a good quality application takes time. Orientation to the application requirements, team-building, drafting, review and revision require a cohesive and well-led process to result in a successful application. Countries enacting the principles of inclusiveness and alignment with national plans and systems may find that these processes add considerably to the time frame for both application and implementation start-up. In accordance with the HSS funding window of predictability, support is available for—and limited to—the life of the national health sector strategy or plan. Therefore, timelines for HSS implementation vary depending on the timing of application vis-à-vis the national health plan.

It should be noted that for GAVI HSS, as an innovative and newly launched initiative, delays are to be expected. While these delays in implementation may impact on the short-term achievements of GAVI HSS, they are equally applicable to other global initiatives supporting HSS under similar principles of inclusion, country alignment and harmonization. An impetus to implementation occurs when GAVI HSS funds are directed into a clearly prioritized and on-going program.

A. Preparing GAVI HSS proposals/applications

The Tracking Study provided an assessment of the GAVI HSS application process in the Phase 1 Synthesis Report (JSI and InDevelop-IPM, February 2009). Among the key findings from that earlier analysis are the following:

- GAVI HSS application processes and content were viewed as aligned with national health strategic plans and priorities. There is a lesser degree of alignment between GAVI HSS and existing national procedures and systems (e.g., procurement, financing, M&E, reporting).
- The Tracking Study Team notes considerable variation, by partner, in the level of inclusion in the application process. The nature of donor involvement varied across the six countries but multilateral partners, notably WHO and UNICEF, were consistently highly involved throughout and satisfied with the application process. Typical of comments heard from multilateral

participants was the following: "*…this [GAVI HSS application] was the first and best document of this type, the process was really participatory, government-led, widely reviewed and endorsed.*" Input from bilateral development partners was a less apparent but important technical resource in several countries. International financing institutions (IFIs) appeared to be the least involved partners within the international donor community.

With a few notable exceptions, civil society organizations (CSOs), notably Non-Governmental Organizations (NGOs)/Private Voluntary Organizations (PVOs), appear to have limited involvement in the GAVI HSS application process. Both NGO and PVO engagement is typically limited to a late-stage review function as members of already established coordinating committees.

B. Start-up and implementation across the six countries

Through the methods described above, the Tracking Study examined the status of implementation, by component or activities, in each of the six countries. Implementation was facilitated when GAVI HSS funds represent an infusion of funds into prioritized activities fully consistent with the national health sector strategy. It was also clearly important to have preparatory steps completed; for example, where large-scale training was envisioned, a training curriculum and materials were ready for use.

Bottlenecks to implementation were examined from the perspective of the implementers and analyzed by the Study Team. Notable bottlenecks include the following:

- Basic structures and mechanisms that would indicate a country's "readiness to implement" are not in place and ready for disbursements to begin.
- The amount of time required for pre-implementation preparatory activities are underestimated.
- GAVI HSS funds arrival "off-cycle" (with fiscal-year planning) creates delays in funds disbursement from national to sub-national levels and creates problems with full utilization and expenditure reporting within the given time frame.
- Cost escalation of commodities results in target modification.

This section summarizes the implementation performance within specific activity areas for each country's grant. Performance here is defined as progress within specific activity or component areas with reference to the stated indicators and targets. The challenge in making this cross country comparison is in discussing implementation performance across grants which vary significantly in both scale and scope. Using these parameters, performance in one country might be measured against the drilling of 47 boreholes while in another it is the launching of a nation-wide health commodity supply system—from policies and manuals to construction of warehouses. Far more detailed and contextualized information is available in the country Case Studies, which accompany this Synthesis Report. Country-specific tables which summarize performance against grant activities appear in Annex IV.

There is an important caveat in describing implementation bottlenecks related to the GAVI HSS. Many of the gaps observed by the Study Team are not specific to GAVI HSS funding but rather pertain more broadly to the implementation of the national health sector strategy and HSS efforts in general. Therefore, it is important to review the GAVI HSS implementation status described here in light of the overall performance of the health sector and commonly encountered obstacles to implementation.

1. Democratic Republic of the Congo

Summary: *Implementation of major components were delayed due to the need to create program and financial management structures. GAVI HSS funds have been catalytic in developing new structures for financial management and accountability with responsibilities for multi-donor HSS resources.*

Implementation experience: GAVI HSS funds in DR Congo are used to support a central element of the Health Interim Plan 2007-2011 (IP), namely, the revitalization of the health zones by tackling some of the main problems that prevent them from operating properly.

The IP and the GAVI HSS proposal have identified salary supplements, capital costs, and drugs as prerequisites to improving immunization coverage and other priority program service delivery. In support of this program, the bulk of the GAVI HSS grant of US $56.8 million will be distributed for salary supplements, health facility infrastructure, and equipment and drugs supplies to regional drug warehouses and health zones. Additionally, funds will also be provided for technical assistance and training at the health district, provincial and central health levels.

The single largest element of DR Congo's GAVI HSS grant goes to supplementing the salaries of health district personnel and a limited number of personnel at the central level. This line item accounts for 25 percent (US $14.3 million) of the total grant. In 50 of the 65 health districts targeted in the proposal, staff will receive salary and bonus supplements. These supplements are to be paid in districts receiving exclusive GAVI support as well as in a certain number of districts supported by other development partners (i.e., USAID and UNICEF) unable to pay such incentives due to their own in-house regulations. Local NGOs operating in those districts will manage and distribute salary supplements to health zone personnel.

As of August 2009, this activity had not been initiated. The transfer of funds to the managing NGOs depends on the selection and establishment of a fiduciary agent, but that agent, who will assume responsibilities for multiple sources of HSS funding, was not selected until August 2009. Individuals within DR Congo expected a fund transfer to NGOs and subsequently to health zones to start before the end of 2009. As of December 2008, only US $108,520 of the total grant (or 0.2 percent) had been expended. However, procurement actions were initiated in 2008 for large-ticket items that are expected to result in total expenditures of only US $14 million by the end of 2009.

Equipment and infrastructure for health zone health facilities comprised the second largest line item of the GAVI HSS grant, totaling 23 percent (US $13.1 million). Needed infrastructure funds were identified in health zone development plans (submitted to the central level in April and May 2009) but have not been disbursed due to the absence of the fiduciary agent mentioned above.

Orders placed in late 2008 for vehicles, medical equipment, and computer equipment (totaling US $1.8 million, US $6.1 million and US $215,000, respectively) are awaiting border clearance at different points of entry. Mechanisms used for the procurement included the United Nations Office for Project Services (UNOPS) (vehicles and computer equipment) and UNICEF (medical equipment). These expenses represent a burn rate of 60 percent of the funds allocated for infrastructure and equipment.

Drugs were procured through the country's regional warehouse drug pooled procurement and distribution system (FEDECAME), with US $3.0 million committed by the end of 2009. This represents a burn rate of 33 percent of the funding earmarked in the GAVI HSS proposal for this purpose.

NGOs with a long tradition of managing, maintaining and equipping health zones and districts in DR Congo will be in charge of the rehabilitation of designated health facilities. However, as of July 2009,

funds had not been forwarded nor were the number of facilities to be rehabilitated known. A situation analysis, conducted by the Kinshasa School of Public Health, will be used to determine the number of facilities needing medical equipment and infrastructure development. The results of the situation analysis will be available by December 2009. Unfortunately, this important preparatory activity is coming after the submission of zonal plans for infrastructure rehabilitation, and decisions were made on how and how much to invest in each health zone.

Progress toward expected outcomes: With only 17 months since the first disbursement of GAVI HSS funds, the low burn rate, slow implementation, and resources (in the form of equipment, rehabilitation of structures and salary supplements) not yet received by the health zones, it is premature to expect coverage and health situation improvements. Further, with the grant originally slated to end in 2010, the indicator-specific targets for most inputs and outputs will not be realized.

Key implementation issues: The major delay in implementation of the GAVI HSS grant in DR Congo is due to the time involved in the creation of national-level management and accountability structures (i.e., a Project Management Unit [PMU] and the fiduciary agent). A related factor is the lack of day-to-day management capacity for project oversight. A decision was taken to house the GAVI HSS in the Direction of Research and Planning (DEP), a unit which has neither the necessary implementation experience nor capacity. To date, these responsibilities have fallen largely on a single individual whose work is not limited to overseeing the GAVI HSS funds. Recently, a staff person has been hired with sole responsibility for GAVI HSS, and management oversight is transitioning from DEP to the newly created MoH PMU. The new roles and responsibilities vis-à-vis the PMU, the fiduciary agent and DEP have an associated learning curve and may result in additional implementation delays.

2. Ethiopia

Summary: *Implementation of major components were spurred through the use of contracts for large-scale procurement and distribution of health post supply kits (UNICEF) and facility renovations and upgrading (GTZ [German Society for Technical Cooperation]). Large-scale refresher training for Health Extension Workers (HEWs) proceeded rapidly as the curriculum was ready for use. Among activities delayed are equipping health centers and rolling out the Health Commodities Supply System.*

Implementation experience: GAVI HSS funds in Ethiopia are used to support and fill gaps in the implementation of the National Health Strategy Development Program-III (HSDP-III), notably the Health Extension Program (HEP). At the core of the HEP is an outreach program intent on posting two HEWs and constructing and equipping a health post in each kebele. In support of this program, the GAVI HSS grant of US $76 million is distributed as follows: the majority (62 percent) is invested in supply, distribution and maintenance of PHC drugs, equipment and infrastructure; 20 percent is used for improving the organization and management of health services; and 18 percent is invested in health workforce mobilization, distribution and motivation. This section summarizes implementation performance in several major activities within these three themes.

The single largest element of the GAVI HSS grant in Ethiopia is a large-scale effort to procure and distribute equipment kits for over 7,000 health posts in all regions of the country. This element accounts for 26 percent of the total GAVI HSS grant and was contracted by the Federal Ministry of Health (FMOH) to the UNICEF country office. UNICEF is operating on behalf of other partners as well, including GFATM, to procure and equip health posts. Two types of kits (Type A and Type B), specific to the services to be delivered in a given health post, are procured.

Table III.1 Delivery of GAVI HSS-financed Health Post Kits, September 2007 to June 2009

	Full kit type A			Full kit type B			Total
	Batch 1	Batch 2	Total Type A	Batch 1	Batch 2	Total Type B	
Total	1,169	326	1495	2500	958	3453	4948
Target	1,170	1,170	2340	2500	2500	5000	7340
% achieved	100%	28%	64%	100%	38%	69%	67%

Source: UNICEF = in progress

Delivery of a health post kit includes explaining and providing some basic training on using its contents, assembling a delivery bed and other pieces of equipment, collecting GPS coordinates, and taking digital pictures. Between September 2007 and June 2009, UNICEF distributed 67 percent of all planned GAVI-funded health post kits (Table III.1). At the time of the Tracking Study, the second batch of GAVI HSS-funded kits was being delivered, with an anticipated completion date of August 2009.

The Tracking Study team conducted observations and interviews in a range of health posts, including some that were not slated to receive the GAVI-financed supply kits. During site visits, the Tracking Study team found that most health posts had cold boxes and provided periodic vaccination with vaccines brought from the health center (characteristic of type B health posts). In health posts with refrigerators, kerosene was oftentimes absent.

A second major activity under this theme is upgrading health stations to health centers. This activity, representing 25 percent of the total GAVI HSS grant, was contracted by the FMOH to GTZ. As with the UNICEF-contracted activities, GTZ is performing the construction and upgrading role with funding from multiple donors. Seventy of the 212 planned GAVI-funded upgrades have been completed, which is below the number planned for completion by this point in the program (177). As with the new construction of health centers, this activity has been impacted by cost escalation in materials. Delays in site assessments and limited contracting companies in remote areas have also been noted. As a result, although there is progress, the target is not likely to be fully achieved by the end of the GAVI HSS-funded period.

Another major activity under this theme, equipping 300 health centers, has yet to be realized. Although initially planned for UNICEF-contracted implementation (as with equipping health posts), the FMOH decided to procure and distribute the health center equipment through the Pharmaceutical Fund and Supply Agency (PFSA), a newly created unit of the FMOH. By this point in the program, it was expected that 30 type A and 225 type B health centers would be equipped. As health center equipment is scheduled to arrive in port in September 2009, although progress toward the target of fully equipping health centers will be made, it is unlikely that targets will be fully achieved by the end of the GAVI HSS-funded program (June 2010). Experience with this procurement and distribution system will be an important test of the new PFSA.

Under the theme, *to improve the organization and management of health services*, a major activity was support for the implementation of the Health Commodity Supply System (HCSS). This activity represents 10 percent of GAVI HSS funds in Ethiopia. Implementation under this area was delayed due to

preparatory steps needed for the HCSS master plan, including organization of the new Pharmaceutical & Medical Supplies Import & Wholesaler Share (PHARMID). In 2008, the remaining monies were reprogrammed to construct regional distribution hubs for the PFSA.

An important and highly visible activity financed through the GAVI HSS grant is Integrated Refresher Training (IRT) for HEWs, an activity under the third theme: *health workforce mobilization, distribution and motivation*. This 18-day training addresses the HEWs' knowledge and skill gaps using a flexible, modular approach. By the end of 2008, a total of 18,362 HEWs had IRT training, a cumulative achievement of 85 percent of those targeted.

In contrast to the activities described above, IRT is conducted by the Regional Health Bureau (RHB), with funds transferred from the FMOH to the region. Expenditure reporting from the regions shows that these training activities constitute a significant proportion of regional-level GAVI HSS spending.

In interviews, HEWs reported having participated in one more training session and believed that their knowledge was significantly enhanced through the sessions. However, the Tracking Study team observed that not all IRT trainees are provided with the standard manual for future reference after training. Inadequate follow-up of the trainees after IRT was a commonly cited problem.

Progress toward expected outcomes: By bringing services closer to the community, the large-scale training and deployment of HEWs, the construction and equipping of health posts, and upgrading of health stations, have the potential to bring about significant improvements in coverage and use of proven interventions. In Ethiopia, 27 months have passed since the first disbursement of GAVI HSS funds. Several sources are beginning to point to progress towards improved child health outcomes related to the implementation of the HSDP-III, of which GAVI HSS is a contributor. While anecdotal, managers interviewed at the regional, zonal and woreda levels expressed certainty that these activities were already contributing to improved health status. The Mid-Term Review of the HSDP-III concluded that there are strong indications that HEP has contributed to improved health-seeking behavior although the data required to substantiate this finding are still being generated. In addition:

- Immunization coverage estimates generated through both routine reporting and household surveys show substantial increases in immunization coverage rates.
- A recently completed multivariate analysis[10] demonstrates a positive relationship between the "intensity" of HEP implementation (measured by the number and duration of HEWs in the community, number of home visits, etc.) and the use of a range of maternal and child health services. Controlling for other factors, the L10K study found that a relatively high rate of home visits by an HEW is associated with higher latrine use, CPR, and childhood immunization in the community. The same study showed that 36 percent of women with infants (0-11 months) reported that they visited a health post in the last year for childhood immunizations.

Key implementation issues: Two conclusions about implementation emerge from the Tracking Study in Ethiopia. First, many of the bottlenecks observed by the Study Team were not specific to GAVI HSS funding but rather pertained more broadly to the implementation of the HEP and the HSDP-III. Second, the team also found that the capacity for HSS implementation varies widely across regions and levels.

[10] The Bill and Melinda Gates Foundation funds the "Last 10 Kilometers" project (L10K), which works in 115 woredas across four regions. The L10K project is focused on support for the HEP, with implementation supported by JSI. A baseline survey was conducted from December 2008 to January 2009.

With the majority of HSS funds expended at the FMOH level, management and coordination at the FMOH is fundamental. The FMOH chose an efficient means for conducting large-scale implementation at the woreda level by contracting with development partners (UNICEF for equipping health posts and GTZ for upgrading health stations).

An important indicator of continued performance will come with the transition to the newly created FMOH PFSA, which will be responsible for equipping 300 health centers, an activity expected to be implemented over the four-year grant life cycle. Similarly, activities related to the HCSS were delayed due to needed preparatory activities for the new structures. A fundamental balance is needed in the implementation of HSS-funded activities—between going through existing, albeit external, mechanisms with readiness to implement (UNICEF and GTZ) or channeling funds to nascent national structures (e.g., the PFSA and the HCSS), which may build capacity but at the expense of full and timely implementation.

Limited capacity to implement is apparent at sub-national levels. Interviews with individuals across three regions revealed surprising consistency in the challenges encountered. Again, while some problems are not specific to GAVI HSS funding, several commonly voiced challenges are. Among these are:

- Arrival of GAVI HSS funds "off-cycle" with fiscal year planning in regions and zones–creating problems with full utilization and reporting within the time frame.
- Wide-spread problems with expenditure reporting due to overburdened finance staff and lack of capacity in financial reporting.

Other bottlenecks to implementation pertain more broadly to the HEP. These include infrequent and inadequate supervision activities, lack of transportation, and lack of adequate technical and administrative capacity at the woreda. In addition, problems were frequently cited with the cold chain (spare parts and/or kerosene for refrigerators), a finding also cited in the Mid-Term Review of the HSDP-III, as follows: "The lack of maintenance of the cold chain, due to lack of qualified cold chain technicians, spare parts and more important, a comprehensive and robust maintenance system, requires urgent attention to preserve the potency of vaccines." Some HEWs further complained that the cluster system in which vaccines are stored at the health centers and brought periodically to the health post was an obstacle to routine service provision and an inconvenience to the community.

3. Kyrgyz Republic

Summary: *Initial disbursement and early implementation were delayed by the need to create a new account for the GASVI HSS funds. Activities are underway as planned with some delay in the creation of mobile health units for villages without facilities and some revision in targets for vehicle procurement due to cost escalation.*

Implementation experience: Implementation of GAVI HSS-funded activities started in 2008 after a delay in initial disbursement of funds from the GAVI Secretariat to the Kyrgyz MoH. The reasons for this delay are described in Section IV of this report. As a result, program time frames were shifted, and planned procurements were delayed. Another cause of delay was the concurrent introduction of pentavalent vaccine, which slowed down the development of some of the GAVI HSS-funded activities. The Tracking Study assessed the status of implementation 23 months after the first tranche of funding was disbursed.

Within the GAVI HSS investment in the Kyrgyz Republic, one component accounts for 58 percent of all GAVI HSS funding: *improving access to high-quality primary care through capacity building, improved management and introduction of economic incentives*. Staff training, supervision and outreach to remote populations are the main activities within the component. Generally, capacity building for

primary health care providers through training is progressing, with minor management modifications required to improve it. Fifteen feldsher trainers have been trained against 26 planned; and 170 immunologists, feldshers and nurses have been trained on "Immunization in Practice" against 420 planned. In addition, the GAVI HSS support is funding operational research on provider motivation/incentives. Funds are being used to initiate a new approach to the supervision of provider performance; the approach consolidates multiple check-ups on service providers carried out by various authorities. Methodological guidelines have been developed and approved by the MoH. The methodology is being piloted in health facilities in the Chui oblast, with Republican Center of Immune-prophylaxis (RCI) leading the process. After finalization of the pilot, training activities are expected to start during 2009.

To ensure immunization and MCH service coverage in villages with no feldsher-obstetrician unit, mobile groups were to be organized as GAVI HSS-funded activities. The mobile teams would be comprised of an "immunologist" (vaccinator), family doctor and other health professionals, and would make four rounds of visits per year. Vehicles for the team's use are those available in health facilities operating in the rayon or oblast centers, including vehicles supplied under GAVI HSS. The arrangement of mobile groups has not progressed according to plan. The MoH is currently estimating requirements for mobile groups and making organizational arrangements.

With the GAVI HSS funds, the Kyrgyz Republic is conducting operational research to pilot the implementation of the bonus payment system. A number of indicators were selected during 2008 for the calculation of the bonuses, and base-line values were collected. After developing guidelines in September 2008, the incentive system was piloted in two rayons, beginning in October of that year. Family Medicine Centers in these rayons will receive bonus payments from the GAVI HSS project until the end of 2010. Initial indications are that the bonus payment system is operating in accordance with its design and beginning to have the intended effect.

The second largest component of the HSS grant, *to improve physical infrastructure and working conditions of primary care and public health services,* accounts for 21 percent of the GAVI HSS grant. In this area, several of the targets included in the proposal have been modified due to a miscalculation in cost which did not factor in inflation and rising costs for procurement. For example, 26 vehicles were to be procured through the HSS funds, but only 18 have been purchased. These vehicles have been distributed, with two vehicles for each oblast and two for Bishkek and Osh, with the oblast Sanitary-Epidemiological Surveillance Service Centers as recipients. The vehicles are used for immunization purposes as well as other needs. In the near future, they will also be used for supervisory visits and mobile teams. It has to be noted that 18 vehicles are not sufficient; ideally, it would be more efficient to have a vehicle for each rayon, according to most facility health managers who were interviewed. The numbers and type of refrigerators procured for vaccine-storage in health facilities has also undergone revision. In part, these revisions were related to the receipt of specialized vaccine refrigerators from the Japanese Government, with UNICEF ensuring the logistics of the refrigerators.

Progress toward expected outcomes: Official estimates are that overall DTP 3 coverage, already at high levels, is moving in line with targets set under the Multi-year Plan of Immunization in Kyrgyzstan. However, with the delayed start and the relatively small role of GAVI HSS funds vis-à-vis the Government and other donors, it is not possible to discern the contribution of GAVI HSS to changes in health outcomes.

Key implementation issues: In the Kyrgyz Republic, there was a delay in start-up because of the country's original intent to put GAVI HSS through the SWAp pooled funding mechanism. That intent had to be re-examined once Government officials realized that GAVI, as an Alliance, could not sign the joint

financing agreement required by the other donors. Also, inflationary factors caused the available funding to be devalued to the point where, by the time implementation began, there was less actual funding available than required to carry out implementation.

4. Nepal

Summary: *Implementation is progressing with major components, including preparatory steps for the construction of health posts with birthing centers and conduct of CB-IMCI training. Planned procurement of vehicles has been delayed due to issues with the tendering process. Training of Village Health Workers from low-performing districts has proceeded according to plan.*

Implementation experience: GAVI HSS funds have been used to complement and fill in gaps to support the objectives of the National Health Sector Program—Implementation Plan (NHSP-IP) and the Government's Three-Year Plan. Eleven activities aimed at low-performing and underserved districts are targeted to reduce childhood morbidity and address system-wide barriers in the health system which prevent better immunization coverage and delivery of maternal and child health care interventions. The total amount of the US $8.67 million, two-year grant ranges over three themes: Theme I, *health workforce mobilization, distribution and motivation,* receives 44 percent; Theme II, *improving organization and management of health services*, accounts for 34 percent; and 22 percent is devoted to Theme III, *transportation, communication, and infrastructure*. The following provides a summary of the activities receiving the majority of funding.

Under Theme II, the construction of health posts with birthing centers to establish a new standard of maternal and neonatal care is being completed in 42 selected sites, accounting for 30 percent of total GAVI HSS funds. The construction of the birthing centers is being managed and implemented by the Management Division (MD) of the Department of Health Services (DoHS) in conjunction with the Department of Urban Development and Building Construction (DUDBC). The DUDBC prepared and received approval for the design of the birthing centers. The design has been forwarded to the respective district offices responsible for issuing and awarding the tenders to the local construction companies. The selection of the 42 districts was also completed. From January 2009 to May 2009, three contracts had been awarded, and it is anticipated that the remaining 39 tenders will be awarded by the end of the fiscal year. The health posts are scheduled for completion in the second year of the grant.

The Tracking Team spoke with the focal person of the DUDBC, who noted that the approved budget for each of the health posts was very tight. There are also insufficient funds to monitor the progress of the health posts and, therefore, additional funding from the MoHP to the DUDBC is needed to set up a monitoring and supervision mechanism, which currently does not exist. District health staff remarked that although the construction of the health posts is a necessary addition to deliver services, they were apprehensive as to the availability of human resources and adequate equipment to sufficiently operate the health posts.

The next activity receiving the largest amount of funding relates to the Integrated Management of Childhood Illness (IMCI) strategy with the expansion of Community-Based Integrated Management of Childhood Illness (CB-IMCI) to the remaining 11 out of 75 districts in Nepal and piloting of CB-NCP in two districts. This activity makes up 24 percent of total GAVI HSS funding and has been contracted out to several local NGOs, including the Nepal Pediatric Society, which has worked on IMCI since 1996. District-level NGOs have also assisted with the rollout of CB-IMCI, including the Nepali Technical Assistance Group, which conducts training at the village development committee and municipality level, INFOAIDS, SUDIN Nepal, and Youth of the World. At the time of the completion of the Tracking Study, all 11 districts had received CB-IMCI training. The CB-IMCI facility-based training modules were modified from WHO/UNICEF and included a program management component and material on basic health workers

developed by WHO and SEARO/CARE. The modules were adapted and translated into the Nepali context and language. Additionally, WHO treatment protocols were adapted and simplified to enable community-level workers to treat children. During field visits, the Tracking Team noted that the quality of the training was high in the three districts observed. However, the small number of observations and the diversity of cases (2 to 4 cases per day) minimized the ability of the participants to acquire adequate hands-on skills. Another observation was the need to conduct refresher training for those who completed their training more than five years ago and for those who missed the training as a result of frequent inter-district staff transfers.

The CB-NCP is being piloted in eight districts, two of which are being funded by GAVI HSS grants. The other districts are being funded by UNICEF (three districts), CARE (one district), and Save the Children USA (two districts). A curriculum has been field tested along with a training package, baseline survey tools, and a logistics management plan. A regional Training of Trainers has been held and implementation of the CB-NCP in the two districts will take place in the next fiscal year.

Seventeen percent of GAVI HSS funding will be directed towards the purchase of 50 pick-up trucks and 100 motorcycles, the third largest HSS activity. The Logistics Management Division has been responsible for issuing the tenders for these vehicles. Because of the elimination of tax-free status on Government-procured goods, the number of trucks budgeted fell from 50 to 37. A second tender had to be issued for the pick-up trucks because all of the responses from the first tender did not meet the required specifications. The award for the motorcycles has been completed, and all of the vehicles will be distributed next year.

Another key activity is the training of an additional 1,200 Village Health Workers (VHWs) in the lowest-performing districts in Nepal. Constituting 14 percent of the HSS budget, the National Health Training Center has been responsible for the implementation of this activity at the regional level. The 35-day training allows VHWs to refresh their knowledge on problem identification, delivering MCH and immunization services, communicable disease prevention and control, Health Management Information Systems (HMIS), Logistics Management Information Systems, leadership management, and a number of other components. The district health offices (DHOs) made arrangements to minimize the impact on routine programs and activities while the VHWs were away for training. Through field observations, the students expressed increased motivation because of the training and were satisfied with the curriculum. Some noted the need for more updated reference materials to facilitate the training. All 1,200 VHWs received their training as planned.

Progress toward expected outcomes: Since Nepal has just completed the first year of GAVI HSS funding, it is too early to observe any direct or indirect improvements.

Key implementation issues: The release of funds for the fiscal year was delayed by three months, thereby impacting all activities in the health sector. Because HSS funding is aligned and integrated within the national health sector framework, it is subject to the same procedures and approval process as other funding sources, although it is not part of pooled funds. Subsequently, HSS funding was also delayed. Despite this, many of the activities planned for the first year have been completed or progress has been made. The preparation needed to develop the Urban MCH strategy has caused a slight delay, shifting the completion of this activity to the next year. At the time of the Tracking Study, the selection of districts to receive vehicles had not been made.

Additional follow-up, supervision, and training may be needed for the districts to see an improvement in accurate and timely reporting to the central level and fully realize the potential of the upgrade in communications and computerization of the HMIS. Health workers interviewed in one district expressed

the desire for a longer orientation period of 3 to 4 days as well as the provision of a user's manual to serve as a reference guide and to assist with troubleshooting. In another district, many of the staff were not able to use the HMIS since they had not received any orientation to the software yet.

Although this issue cannot be controlled by any of the parties involved in implementation, further currency fluctuations may impact the completion of planned activities. This year, an increase in per diem rates led to a reduction in micro-planning from 10 districts to 5. Many of the health posts have not begun construction, and material costs could affect the ability of districts to meet the budgets set for building these facilities. Close communication among the Nepal Ministry of Health and Population (MoHP) and the divisions managing HSS activities will need to continue, not only to monitor activities but to ensure that activities that may need additional funding from either the government or donors receive such funds.

5. Vietnam

Summary: *Implementation of major components is progressing but behind the planned timeline. The time required to develop a curriculum and associated training materials has delayed the training of village health workers.*

Implementation experience: In Vietnam, 23 months have passed since the first disbursement of funds. In spite of initial delays described in the Case Study, almost all activities are progressing, although not according to the planned timeframe.

The primary component of the HSS grant in Vietnam is aimed at increasing the number of village health workers (VHWs) and improving the quality of their work. Sixty-six percent of all grant funds are devoted to this component. The single largest activity under this component (US $6 million) is development of a curriculum and materials and training of VHWs. Implementation started in October 2007 with a kick-off workshop with 10 targeted provinces followed by drafting of a proposal for a baseline survey and compilation of training curricula for commune and VHWs. In 2008, the Science and Training Department of the MoH updated the VHW training curriculum, taking into account the socio-economic context in 10 project provinces. Based on the updated training curricula, training materials were revised during 2008 and 2009. As of this date, training materials have not yet been finalized and distributed to the provinces.

Nonetheless, 3 of 60 planned training courses were completed in 2008, and 57 are planned for 2009. By this point in the HSS-funded activity, well over 1,000 VHWs should have received the nine-month training; however, only 120 have done so. Qualified trainees will be provided with a standard certificate allowing them to practice as formally trained and professional VHWs. With this certificate, the trained VHWs report feeling greater job security and having a stronger attachment to their work. Only 37 percent of VHW trainees interviewed had received training before the GAVI HSS project and, of those trained, most had received training for one month.

Another activity under the VHW component was the provision of a monthly allowance, based on performance, to VHWs (US $2.7 million). A total of 16,389 VHWs have received the additional monthly allowance from the HSS project. These allowances have differing levels (50,000 VND; 45,000 VND and 35,000 VND), which correspond to three levels of performance, respectively, A (very good), B (good) and C (poor). The performance-based incentive scheme was expected to make the VHWs competitive with each other and thereby to promote improved performance on their part. However, almost all received the highest level of additional allowance. Most VHWs rated the allowance received from the GAVI HSS project as low, with only one-third of the VHWs interviewed reporting the support as important or very important to their income. Although, overall, the procedure for receiving money from the project was rated acceptable and good, about 20 percent thought that it was still complicated.

As a supportive element to the VHW training, the HSS proposal included development of a manual/guideline for VHW and Commune Health Center (CHC) monitoring and supervision (US $1.2 million). These materials were developed by the MoH and a local consultant in 2008 and are available for use. The MoH plans to organize Training of Trainer (TOT) courses in 2009 for provincial trainers responsible for training district and commune health workers. In the Tracking Study's survey of staff at health facilities, it was found that 84 percent (73 staff) said that supervision was carried out, on average, five times in the last year. The supervisory visits are integrated and not carried out separately for the GAVI HSS-funded activities.

Under a second component, the GAVI HSS grant aims to improve the quality of work of commune health workers (CHWs) and expand the reach of the CHCs. A total of 69 training courses for CHWs on "Immunization in Practice" were organized by PHDs with support and coordination from the National Expanded Program on Immunization (EPI) in 10 project provinces. The available guidelines jointly developed by the EPI Program in Vietnam and WHO were used for these training courses.

The GAVI HSS funds are used to provide 1,674 CHCs in the 10 project provinces with additional recurrent cost support of US $30 per month. This element, totaling US $1.65 million, represents 10 percent of the GAVI HSS grant in Vietnam. These funds partly support CHCs in the most disadvantaged provinces, especially in disadvantaged communes, to cover basic operational costs, e.g., consumables, water, telephone and electricity.

Progress toward expected outcomes: The Tracking Team collected data related to outcomes from annual reports and the PMU. While national trends in key indicators show improvement, it is not possible to discern what, if any, contribution that the GAVI HSS funds may have made to the improvements in outcome indicators. GAVI HSS-funded activities were initiated in late 2007, albeit largely preparatory. In addition, GAVI HSS funds are directed towards 10 provinces, while data reported is for the national level. Data from a baseline survey conducted in the project's 10 regions were available in late 2008. It is unclear whether a follow-up survey is planned.

Key implementation issues: **T**he Tracking Study team collected monitoring data from the annual reports and from the PMU on implementation status as of May 2009. Progress has been verified at field visits to three provinces, where quantitative and qualitative data were collected. There are clearly some activities that either were not done or not completed due to the delay in funding. In general, preparatory activities, such as curriculum development or computer procurement, required longer than anticipated periods, thus causing delays in implementation. Due to the delays encountered, some but not all activities planned will actually be accomplished before project completion.

6. Zambia

Summary: *Implementation is well-advanced. Vehicle procurement required almost one-year, a typical timeframe for procurement. Facility improvements are underway, with some components nearing completion. Income-generating activities have been delayed due to cost escalation.*

Implementation experience: The level of implementation at the time of the Tracking Study had reached an advanced stage, with all the sampled districts having received all the funds and items according to plan for the implementation of GAVI HSS activities. A majority of the planned activities had also been either fully implemented or were underway. However, the study team also found that activities had been delayed by approximately one year, partly due to the late arrival of funds in relation to the fiscal year and partly due to the fact that the project had to be synchronized with the existing planning and budgeting cycle in Zambia.

The Study Team found that procurement of goods (constituting about 60 percent of the total project value), which was taking place at the central level, had been carried out more or less according to plan. The procurement process started in January 2008 and was finished in December the same year. The process was lengthy (9-11 months), but within what could be expected for these types of procurements.

The Study Team found that disbursements of funds to the districts were also made according to plan; however, the timing had to be synchronized with the normal planning and budgeting cycle in Zambia. The first transfer of funds to the districts was made in June 2008 after a planning and orientation workshop with the districts, in order for the districts to be able to include GAVI HSS activities in their plans for the coming fiscal year. Part of the funding was to be used for procurement of goods and services at the district level, and part was to be used for Income Generating Activities.

Progress toward expected outcomes: Given the delayed start and the relatively small role of GAVI HSS funds vis-à-vis the Government of Zambia and other donors, it is not possible to discern the contribution of GAVI HSS to changes in health outcomes.

Key implementation issues: The Team found several bottlenecks in the implementation of the GAVI HSS activities at the district level. A major bottleneck was communication between the central and sub-national levels (provinces and districts). It seems that the provincial level was left out of the communication between the center and the districts, although the impression at the central level was that the provinces had been oriented and informed about the project. As a result, the provinces did not play the role of supervisor nor were they involved in monitoring the GAVI HSS project to any large extent. It also seems that in the communication with the districts, some were not well informed. Although the districts had been oriented to the project, some did not know how the funds should be used. The study team also found that in some districts the project was considered to be a separate project with separate reporting and monitoring routines, and not necessarily an integral part of the district plans. Another reason, apart from problems in communication, could be the fact that the GAVI HSS funding was not part of the annual district grants, but rather a separate source of funding that used the existing GAVI grant routines.

The Study Team found that in one or two of the districts, the funds transferred from the central level did not arrive as planned. The combination of mistakes in communication and administrative problems in the banking system delayed implementation of activities even further in these districts. Apparently, no action was taken until the supportive supervision team from the MoH, while on a routine visit, realized that the funds for the project were missing.

Out of a total of 47 boreholes planned for in the seven districts, 40 had been sunk at the time of the investigation. Reasons for non-completion of implementation include an increase in the estimated costs due to fluctuations in the exchange rate and a weak procurement process that did not take into consideration environmental constraints, among other issues. In one district, for example, one contractor was contracted to dig all of the boreholes, but by the time half of the boreholes were ready, the rainy season made the rest of the district inaccessible.

The implementation of the Income Generating Activities has also been delayed and is behind plan, mainly due to cost escalation. Other problems found by the Study Team include ones such as health centers receiving vehicles but not having trained staff available to use them.

The implementation experience is, however, that most of the activities that have been carried out have been implemented according to plan. The problems that have been identified have been identified at

the district level; some of them are project specific and some are due to more general system barriers beyond the GAVI HSS project.

IV. Findings - Synthesis themes

In assessing GAVI HSS implementation, the Study Team identified a set of factors and themes that define the context for implementation and may serve to either drive or hinder performance. This section examines those factors and themes with an emphasis on planning, management and coordination, financial flows, monitoring and evaluation, and technical support.

A. Key messages

Planning, management and coordination: Within the Tracking Study countries, responsibility for the management of the HSS-funded activities varies in regard to its institutional placement, reliance on existing government structures and human resources assigned. These variations are related both to the vastly different scales of the HSS grants and the level of funding received by the country, as well as to the existing structures and capacities to manage those funds. To date, these differing management arrangements vary in their ability to meet the needs of HSS implementation. An important case is DR Congo, where the need to establish a fiduciary agent and a Project Management Unit (PMU), among other factors, has delayed full implementation by over 17 months. Within these countries, HSS management across levels (e.g., central MoH, regional health bureaus, and district health offices) is largely guided by existing structures and processes for planning, budgeting and implementation. The degree to which the funded activities are integrated into annual programs of work at these levels varies across countries.

Similar models of coordination are seen across Tracking Study countries with a high-level sector coordinating body (HSCC)—chaired by the Minister of Health and with high-level representation of the donor community—delegating much of the detailed, operational oversight to a more technical sub-group or working group. Minimally, these sub-groups are kept informed of HSS progress, and review and approve Annual Progress Reports (APRs). However, in most countries, these groups are more substantively engaged in GAVI HSS programming, including approving re-programming requests. Formal linkage or communication between these coordinating groups and immunization Inter-Agency Coordinating Committees (ICCs) was not apparent. For the most part, with the exception of two countries—Nepal and Zambia—the immunization program staff were not involved in the design or application of the GAVI HSS grant.

Financial flows: As with the management arrangements described above, countries chose a number of differing financial mechanisms to receive and disburse their GAVI HSS funds. However, unlike the management arrangements—which do not appear to seriously impede implementation—the financial mechanisms can impact implementation. Most countries consider their GAVI HSS funds to be "on-budget" although a variety of pooled and special account mechanisms are being used. Of the four countries with SWAp mechanisms in place, only one (Ethiopia) utilized the same pooled funding mechanisms for their GAVI HSS funding. Of the three other countries with SWAps and pooled funding mechanisms, one (Kyrgyzstan) tried but was unable to pool its GAVI HSS funds with those of other donors; the other two chose to manage their GAVI HSS funds in accordance with their SWAp mechanisms but to channel the funding through separate, non-pooled accounts. Countries cite the need to link and report on their HSS support for specific types of activities and results as the primary barrier

to pooled funding. This is because pooled funding arrangements typically do not permit the donor or the central MoH to dictate or monitor and report on spending at the sub-national level.

In at least three of the countries, HSS funds are utilized for significant[11] central-level procurement of goods and services used and/or delivered at the sub-national level. This arrangement is also seen to result in situations where program managers at intermediate levels (e.g., regions and provinces) are unaware of inputs to and activities in the districts. At sub-national levels, the arrival of GAVI HSS funds "off-cycle" leads to some ambiguity as to whether the HSS activities are part of/included in annual plans.

Monitoring and evaluation: There is insufficient attention devoted to collecting and analyzing output-level measures which reflect the tangible changes in service availability, accessibility and quality that result from the types of investments made through GAVI HSS funding (i.e., human resources for health; supplies, equipment and infrastructure; and management and organization). This gap results in an inability to fully describe the sequence of activities and interim (outputs) and longer-term results (outcomes/impacts), as was intended in the HSS framework.

Technical support: Technical support identified in the countries' HSS proposals has been accessed in some but not all cases. During implementation, several Tracking Study countries are relying on technical support providers—including local professional associations and NGOs, bilateral partners, and multilateral and national consultants—to implement elements of their HSS plans. In general, the Tracking Study countries rely on longer-term, locally available sources of technical support, such as bilateral projects or WHO or other in-country partners, rather than acquiring short-term external assistance.

Technical support during early implementation/start-up would have been enormously helpful to the Study countries in helping them to develop both a realistic implementation plan that takes into consideration implementation issues (such as long lead times for procurement or the need for curriculum development prior to training) as well as realistic and useful monitoring and evaluation plans. The significant role of CSOs and NGOs in supporting implementation can be juxtaposed with HSS proposal development processes where little direct involvement of these groups was reported in most countries, with the exception of Nepal and DR Congo.

B. Planning, management and coordination of GAVI HSS

Within the Tracking Study countries, responsibility for the management and coordination of the HSS-funded activities resides either in planning and finance units (Ethiopia, DR Congo and Kyrgyz Republic) or in the MoH unit responsible for child health/immunization programs (Nepal[12] and Zambia) (see Table IV.1). Across countries, GAVI HSS support has largely been managed and implemented through already existing government structures. In most cases, staff assigned to manage the GAVI HSS grant are existing MoH employees.

Two countries have either created or are in the process of creating PMUs to manage the GAVI HSS funds. In Vietnam, a unit was created specifically to manage and oversee the HSS grant, albeit drawing from existing staff in the planning and finance unit. This is because in Vietnam there is a Ministry of Health regulation that stipulates that all external funding over a certain amount must be managed as if it

[11] ≥ 67% of GAVI HSS funds

[12] In Nepal, management responsibility was shifted from the Department of Health Services (DoHS)/MoHP to the Policy Planning and International Cooperation Division.

were a distinct project in a separate management unit within the Ministry. In DR Congo, a fiduciary agent was recruited and a PMU is being created but with HSS responsibilities beyond GAVI funding.

A summary of management arrangements can be found in Table IV.1. These differing management arrangements vary in their ability to meet the needs of HSS implementation. The clearest case in point is the DR Congo. DR Congo is still in the process of establishing a PMU and has recently contracted with its fiduciary agent. Although the direction that DRC is moving seems logical and will certainly facilitate management of HSS funds in the future, the lack of these two mechanisms (management and financial) at the start of the GAVI HSS grant caused serious delays in implementation. Further, the manpower assigned to HSS grant management varies widely by country and does not necessarily correlate to the size or scale of the HSS funding. Specifically, the staffing devoted to HSS grant management in Vietnam is large in comparison to the size of grant and the experience of other countries. In Ethiopia, the ability of regions and zones to complete expenditure reporting for the HSS funds was a bottleneck. Although this issue is now being addressed in a coordinated management response, additional program management support could have helped regions resolve this problem earlier. Finally, in Zambia, the study team notes that HSS implementation would have benefited from consistent involvement of the MOH planning unit.

Table IV.1 Summary of GAVI HSS Management and Coordination Mechanisms by Country

	Mgt. Unit		PMU		Staff	HSCC/coordinating body			
						Status		Type	
	Plan	Prog.	Y	N	#	Exist	New	HS	ICC
Ethiopia	√			√	1+	√		√	
DR Congo	√		√		1+[i]	√		√	
Kyrgyz Rep.	√			√	2+	√		√	
Nepal		√		√	1+		√	√	
Vietnam	√		√		7-8	√		√	
Zambia		√		√	1+	√			√

[i] A newly created PMU will have a staff of eight to manage GAVI HSS as well as other HSS funds.

The six Tracking Study countries use a rather consistent model of coordination. A high-level coordination body, typically chaired by the Minister of Health, is responsible for coordinating the national health strategy, including making decisions on strategies, annual plans and budgets, and resource allocation. A more operational or technical arm (or working group) of the higher-level forum is empowered to provide more immediate oversight of the HSS activity, among others. In many cases, the planning and finance unit of the MoH serves as a secretariat for the operational/technical arm. It is common that these technical coordinating bodies, with representation from the MoH as well as from donors, would be provided with updates and progress reports on the GAVI HSS activities.

Across countries, coordinating committees have responsibility for reviewing work plans and budgets and approving APRs. Based on discussion in the Multi-Country Workshop, there was lack of clarity and

differing perceptions about the in-country authority for re-programming decisions vis-à-vis the GAVI Secretariat. In several countries, the coordinating committees (DR Congo, Ethiopia, and Kyrgyz Republic) review requests for re-programming and make a decision. The GAVI Secretariat is informed through subsequent communication, including the APRs. In other countries, the perception was that GAVI approval was required before monies could be re-directed toward other activities included in the proposal.

In several countries, MoH immunization program managers are not members of HSS coordinating committee(s). However, respondents point to overlapping membership between the immunization-related ICC and the broader health coordinating committees as an avenue for information sharing. Table 5.2 provides a synopsis of these coordinating bodies.

Country-generated recommendations on improved management arrangements and coordination mechanisms can be found in Annex 5. The descriptions below provide a synopsis of the country-specific management and coordination mechanisms.

In **Ethiopia,** HSS funds are managed and overseen by the Planning, Program and Finance General Directorate (PPF-GD) of the FMOH. PPF-GD provides overall management of the funding, ensures timely release of funds, and monitors and facilitates implementation. It performs this function with a Program Manager to support the GAVI HSS-funded activities and two staff who work, in part, on the HSS grant. These staff are regularly funded employees of the Federal Ministry of Health. In addition, a Global Fund-supported finance staff member assists with HSS implementation. The PPF-GD will also have responsibility for managing the newly signed Global Fund Round 8 grant as well as the newly awarded GAVI CSO grant. Management practices closely follow FMOH-established procedures for procurement, budgeting and reporting.

HSS funds are programmed through several departments at the FMOH, such as the Family Health Department, Health Promotion and Disease Prevention Department, and Health Extension Department. The PPF-GD consolidates annual work plans prepared by the respective FMOH divisions and sub-national levels and submits them to the national health sector coordinating committee, described below.

The highest health sector coordinating body in Ethiopia is the Central Joint Steering Committee (CJSC). Chaired by the Minister of Health, the CJSC gives general guidance for the preparation of health sector strategic plans, annual review meetings, joint review missions and evaluations of the Health Sector plans[12]. The CJSC also approves resource allocations based on a national equity formula. Along with these activities, CJSC oversees the development and implementation of GAVI HSS to ensure that the activities are consistent with the national health sector development framework.

The Joint Central Coordinating Committee (JCCC)—the technical arm of the CJSC—also plays an important coordinating role for the GAVI HSS funding. Meeting on a bi-weekly basis, the JCCC considers issues related to the planning, implementation and review of the HSDP-III. In regard to GAVI HSS funding, the JCCC reviews and has approval authority for re-programming requests (both from the federal and regional levels) and reviews the Annual Progress Report to GAVI. By way of illustration, over the past several months, the JCC has dealt with re-programming or modification requests that include a shifting of US $5.9 million in unspent funds from the Health Commodity Supply System to construction costs for warehouses for the newly formed procurement agency and a re-programming of monies in one

[12] HSDP Harmonization Manual (HHM, 2007)

region from a program activity area where the monies could not be absorbed into areas of greater demand, including supportive supervision and furnishing for health posts. The FMOH immunization program and the immunization ICC are not directly engaged in HSS management and coordination although there is overlapping membership of the JCCC and ICC.

In **DR Congo**, the Department of Studies and Planning (DEP/MOH) has responsibility for managing the GAVI HSS-funded activities. The DEP oversees implementation, monitors and ensures financial reports and budgets (along with a new fiduciary agent described below), and serves as the primary contact with the GAVI Secretariat. The DEP also acts as the secretariat to the national steering committee. Interviewees noted some difficulties in the sharing of plans with other departments and divisions (e.g., EPI, Primary Health Care Division, Disease Surveillance Direction).

A HSS focal point person was to be recruited based on a request from the national steering committee and other donor partners. However, some development partners advocated for the creation of a PMU rather than a single staff position in the belief that a more concerted effort would be required for full implementation of the GAVI HSS grant, as well as for the effective use of other HSS monies. In January 2009, a Ministerial decree authorized creation of a PMU within the Ministry of Health, and a calendar for the establishment of the PMU was developed. Funding for the start-up and operational costs of this PMU will be supported by World Bank, Global Fund and GAVI HSS funds. The responsibilities of the PMU includes tracking progress based on plans and established time schedule, coordinating with partners and the steering committee, reporting, managing contracts with NGOs that receive GAVI HSS funds (in collaboration with the fiduciary agent), and linking with the partners receiving GAVI CSO funds. The PMU is staffed entirely with MoH staff who are being managed and trained by the fiduciary agent hired to oversee the financial management of PMU funds.

The National Steering Committee (Comité National de Pilotage or CNP) is in charge of coordination and decisions regarding HSS implementation. The CNP is presided over by the Minister of Health, and the donors' coordination forum is represented by its (rotating) Chairman and its members. The CNP includes an Ad Hoc Committee, comprised of a member of the Minister's Cabinet, the MOH Secretary General, the DEP, and a rotating member of the donor coordination group, which is responsible for relations with the fiduciary agent and for the overall management of the HSS funds. The Ad Hoc Committee assumes an important role in piloting, monitoring and evaluating the HSS program through approval of annual plans and expenditure planning, review of implementation as well as the financial reports, and initiation of technical and financial audits.

GAVI HSS in the **Kyrgyz Republic** is supervised by the Deputy Minister, Chief Sanitary Doctor of the Kyrgyz Republic, who serves as focal point, supervising the implementation of activities and dealing with difficulties that may arise. The Deputy Minister is supported in this work by a Technical Manager. In addition, the MoH Department of Strategic Planning and Reform Implementation is responsible for coordinating all health systems strengthening activities under Manas Taalimi, the Government's health sector reform program, including coordinating and facilitating planning, implementation and reporting processes. Two positions were established within the MoH to coordinate the implementation of GAVI HSS: a Technical Coordinator and a Financial Manager. The Technical Coordinator works closely with MoH departments, agencies and bodies involved in GAVI HSS implementation and provides a link for the GAVI Secretariat. Financial management issues are handled by the Financial Manager.

Two bodies coordinate the GAVI HSS grant in the Kyrgyz Republic: the Health Policy Council (HPC) and the ICC. The highest organ of policy approval, the HPC, chaired by the Minister of Health and with MoH-wide representation, meets regularly and makes major decisions related to general health policy and

pressing issues of Manas Taalimi implementation, including approval of national and oblast plans of work, budgets and procurement plans. The HPC also reviews HSS implementation and budgets, and approves the APR prior to its submission to the GAVI Secretariat. Linkages between the HPC and the ICC exist through overlapping membership on these bodies. The HPC is coordinated by the Department of Strategic Planning and Reform Implementation. The work of both the Technical Manager and the Finance Manager are supervised by the HPC and ICC.

In **Nepal**, the Department of Health Services (DoHS) within the MoHP is the management unit responsible for the GAVI HSS. The Director General/DoHS is the main decision maker for the overall implementation of GAVI HSS activities. The GAVI HSS focal point, the chief specialist at the MoHP, is responsible for planning, programming, and reprogramming all of the MoHP's programs, including those funded by GAVI HSS. Decision-making processes for spending as well as procurement are bound by Government financial rules, audit procedures, and procurement regulations. For example, budget revisions have been necessary because of currency fluctuations, price changes, and the levy of new taxes since the start of GAVI HSS implementation. In such cases, the proposed budget has been revised on the recommendation of the responsible divisional director and approved by the Director General. The GAVI HSS focal point sees and approves all adjustments to the HSS work plan (e.g., reduction of the number of pick-up trucks procured due to changes in tax status on Government-procured goods). Such program changes, as well as the re-programming of activities due to delayed disbursement and implementation, need the approval of the National Planning Commission.

Activities are supported and carried out by the Child Health, Logistic Management, and Management Divisions, and the National Health Training Center. HSS activities are coordinated through two forums: a National Health Sector Coordinating Committee (NHSCC) coordinated by the HSS focal point and a Technical Working Group coordinated by the Director General of the DoHS. Implementation and progress of the GAVI HSS project activities, for example, reprogramming decisions as part of the approval process for annual plans, are coordinated and monitored in detail by the NHSCC. Coordination also occurs through the sharing of progress reports across divisions, reviews at the national level conducted by the NHSCC, and the joint annual review (JAR), with participation by donors, divisional directors of the DoHS, NHSCC members, civil society members, NGOs, the Ministry of Finance, and the Planning Commission. Coordination between the NHSCC and the immunization ICC is based on overlapping membership, whereby relevant stakeholders, NGOs, and donors such as WHO, UNICEF, and the World Bank are included.

In **Vietnam**, a Project Implementation Unit (PIU) was established within the Ministry of Health (MoH) with 10 members working full or part time for the project. The PIU has direct responsibility for the planning, supervision and reporting of the project. It has close ties to the MoH's Department of Finance and Planning and is headed by the director of that department. The Vice Director of the Department of Planning and Finance serves as the GAVI HSS coordinator. Other PIU staff include the Vice Director of the MoH's Research and Training Department, two experts from the Planning and Financing Department, a chief accountant and accountant, and three additional permanent staff. Day-to-day implementation is done by the PIU and, if necessary, issues are brought up to the national GAVI coordinator (Vice Director of Planning and Financing Department) or to the Director of PIU (also Director of Planning and Financing Department). Based on interviews and a review of EPI ICC meeting minutes, it appears that the PIU has limited (weak) linkages to the national immunization program.

A Health Partnership Group (HPG), established since 2002, served as the sector-wide coordinating body, with participation of all donors in the health sector. Members include the MoH, WHO, UNICEF, UNDP, the World Bank, Asian Development Bank (ADB), European Commission, Swedish International Development Cooperation Agency (Sida), Japan International Cooperation Agency (JICA), Embassy of

Luxemburg, Royal Netherlands Embassy Hanoi, and Save the Children US. The HPG meets every three months to discuss priority issues and concerns related to the health sector. The HPG meetings are normally co-chaired by a Vice-Minister and a representative selected by the donor community. During project implementation, HSS project progress is reported at the HPG meetings for information and comments, and Annual Progress Reports are presented for discussion. Donors who work in the same areas and the same settings have the opportunity to exchange experiences/lessons and discuss how to coordinate their activities.

In **Zambia**, management and coordination of the GAVI HSS project at the central level is primarily a function of the Child Health Unit (CHU) under the Directorate of Public Health and Research (DPH&R). This is a service delivery unit responsible for EPI and other child health-related areas, including all GAVI grants. The unit plays a decisive role during implementation by providing overall coordination, facilitating the approval of district plans and budgets, and undertaking supervisory visits to implementing districts and health centers.

The GAVI HSS application envisaged the coordination of the project falling under the Directorate of Planning and Policy Development (DPPD), a central directorate that provides a wide national overview of health system strengthening activities, information sharing and coordination between other MoH directorates and units. However, the DPH&R and CHU have taken the dominate role in overseeing implementation of GAVI HSS activities, and the DPPD's role seems to have been primarily during the proposal development stage. Interviews conducted at the central and provincial levels for this assessment indicate that this was the weak link with regard to central-level support toward GAVI HSS implementation. However, the same interviewees perceived no difficulties with the Director of DPH&R's management of the HSS grant. They said that this is because the Director has a good understanding of ongoing HSS initiatives, both nationally and at the district level, and can easily coordinate initiatives, projects and activities to avoid duplication. At the national level, GAVI is coordinated by an ICC having representation from various institutions, among them, MoH, UNICEF, and WHO.

C. Financial flows

As with the management arrangements described above, countries chose a number of differing financial mechanisms to channel the GAVI HSS funds. These mechanisms have a varying degree of success in supporting implementation. For example, in at least two cases (Kyrgyz Republic and Vietnam), the decision or need to create a new account for the GAVI HSS funds delayed the receipt of funds by several months, and in the DRC, the lack of a financial division within the MOH to manage the GAVI HSS grant delayed implementation by many months (as described below). In Table IV.2, the following variables of interest are summarized:

- Did the country have a pooled fund available when the GAVI HSS grant was approved?
- If so, was that pooled fund used for the HSS monies?
- What is the status of the account being used to channel HSS funds? Is it an existing account or newly created?
- What are the basic characteristics of the account?

Most countries consider their GAVI HSS funds to be "on-budget" although a variety of pooled and special account mechanisms are being used. Of the four countries with SWAp mechanisms in place, only one (**Ethiopia**) utilized the same pooled funding mechanisms for their GAVI HSS funding. In Ethiopia, the

Millennium Development Performance Fund (MDG Fund) is used by the Federal Ministry of Health (FMOH) to cover funding gaps in implementation of the national health strategy.

Between 2007 and 2009, GAVI HSS funding was the first and only donor support managed through the MDG Fund. Because of the ground-breaking and positive experience, the Government of Ethiopia and other donors have prepared a joint financing arrangement through which additional donors will pool their funding in the same FMOH-managed account. Interestingly, elements of that arrangement may make it difficult for GAVI to continue to use the MDG Fund in any future rounds of HSS funding (e.g., partners agreed that no separate proposals would be required; rather, pooled funds are used to address implementation gaps based on a joint annual assessment).

Of the three other countries with SWAps and pooled funding mechanisms, one (Kyrgyzstan) tried but was unable to pool its GAVI HSS funds with those of other donors because the GAVI Alliance was not able to sign the Joint Financing Agreement demanded by the Government and other parties to the pooling agreement. The other two countries (Nepal and Zambia) chose to manage their GAVI HSS funds in accordance with their SWAp mechanisms but to channel the HSS funds through a separate and non-pooled account. Countries cite the need to link their HSS support to specific activities and to report on the results of these investments as the primary barrier to including GAVI HSS funds in pooled funding mechanisms. In **Zambia**, an existing account for GAVI funds was viewed as the most efficient mechanism for channeling funds and allowed for tracking of the HSS funds.

As described above, **DR Congo** has experienced substantial delays in implementation due to the lack of an existing financial mechanism to manage and disburse funds within the country. This experience should emerge as a clear lesson for GAVI and other donors engaged in health system strengthening efforts on the need to have financial structures and procedures in place as a pre-condition to implementation.

Table IV.2 Financial Flows, New and Existing Mechanisms Used for GAVI HSS Funds by Country

Country	Pooled fund		Account status		Characteristics
	In place	Used	Existing	New	
Ethiopia	Yes	Yes	√		MDG Performance Fund managed by FMOH to fill gaps in HSDP-III implementation; added donors under JFA
DR Congo	No			√	Independent fiduciary agent selected to serve as fiduciary agent; In interim, GTZ plays that role
Kyrgyz Rep.	Yes	No		√	Special account of MoH in Treasury system; SWAp not used due to (a) problems with non-payment of procurement contracts and (b) inability of GAVI Alliance to sign the required MOU
Nepal	Yes	No		√	Earmarked account in MoH financial system based on need to track specific activities and resources
Vietnam	No			√	Newly created accounts (foreign and ntl. currency) within the MoH account system
Zambia	Yes	No	√		An existing USD account used for all GAVI funds

Procurement experience: Once funds are available in country, a common pattern across countries involves significant central-level procurement of goods and services that are used and/or delivered at the sub-national level (see Figure IV.1 and Table IV.3). These goods and services can include equipment and supplies for health facilities, construction and/or renovation of health facilities, development of national curriculum for village health workers, implementation of training programs, and management of health services. A smaller proportion of HSS funds are provided directly to the sub-national levels of the health system (e.g., regions, provinces, districts) for their use.

The pattern of central MoH-level procurement and provision of goods and services to sub-national levels has presented challenges for countries. While clearly an efficient means of managing large-scale implementation, this arrangement is also seen to result in situations where program managers at the intermediate levels (e.g., regions and provinces) are unaware of inputs to and activities in the districts, particularly when these activities are planned and resources are allocated from the central level directly to the districts. In three Case Study countries, regional- or province-level managers lacked complete information on HSS-funded activities occurring within their regions.

Several countries have relied on development partners with well-established mechanisms and procedures to "jump start" large-scale procurement of goods and services. In Ethiopia, for example, the contract with UNICEF to procure and distribute health post kits has resulted in over 7,000 kits delivered in a two-year window. The challenge in this situation, as well as in most initiatives which involve strengthening the health system, is striking a balance between efficiency of implementation (through contracting out for goods and services) and building of the national institutions' capacities. In Ethiopia, an important indicator of continued performance will come with the transition to a newly created FMOH Pharmaceutical Fund and Supply Agency, which will be responsible for equipping 300 health centers, after some delays.

Whether using government and non-governmental procurement mechanisms, the HSS proposal work plans tend to underestimate the amount of time required for procurement processes—thereby creating an almost "built-in" risk of implementation delay. In some cases, actual procurements were contingent on the creation of new national structures and mechanisms for procurement—again an inherent risk in a time-limited implementation.

Table IV.3 Allocation of GAVI HSS Funds for Central-level Procurement of Goods and Services Delivered at Sub-national Levels

Country	% of GAVI HSS funds expended at central level	Purpose of central-level expenditures
Ethiopia	77%	• Equipment and supply kits for health posts • Upgrading of health stations to health centers • Procurement of vehicles and computers
DR Congo	67%	• Procurement of medicines, supplies and equipment for health zones • Contracts to NGOs for service delivery
Kyrgyz Republic	35%	• Analyses/studies • Awareness campaigns • Vehicle and refrigerator purchase • Software development for monitoring
Nepal	87%	• Development of curriculum and training of trainers • Procurement of vehicles and computers • Design of prototype for health posts w/birthing centers; development of software for electronic reporting
Vietnam	13%	• VHW curriculum and training materials • Purchase of basic bags for VHWs • Provision of allowance for PMU members/operating costs
Zambia	60%	• Procurement of vehicles, motorbikes and bicycles

Bottlenecks: Countries described several types of bottlenecks in the flow of GAVI HSS funds. As described earlier, funds that arrive "off-cycle" or out of sync with fiscal year planning and budgeting are held at the central level until they can be synchronized with that cycle. As a case in point, in **Zambia**, the first tranche of HSS funds arrived in October 2007, with the fiscal year ending in December. While central–level procurement processes were initiated in January 2008, the funds designated for districts were held for an additional four months to allow for an orientation workshop and to ensure alignment with the fiscal year planning cycle. The first disbursement to districts occurred in June 2008. Similar situations, (e.g., due to the arrival "off cycle" of GAVI HSS funding) are reported in the Kyrgyz Republic and Nepal.

In the **Kyrgyz Republic**, the GAVI HSS funding could not be pooled as originally intended. A new account needed to be created to receive and manage the transfer of funds from GAVI Alliance to the MoH—complicating the process. The creation of the new account delayed the first disbursement from GAVI to the country, resulting in a delay in implementation and the incomplete utilization of funds. This, in turn, affected the receipt of the second and third tranches and impacted planned implementation.

Nepal also reported a substantial delay (six months) in the transfer of funds from the Ministry of Finance to the Ministry of Health.

Other problems with funding flows have included:

- The delayed arrival of the notification letter (or authorization to expend) from the MoH with the intended allocation of budget by activity (**Ethiopia, Nepal and Zambia**).
- Limited capacity at the sub-national finance offices, along with high turnover of staff.
- Problems with liquidation or expenditure reporting (**Ethiopia**).

Liquidation problems at the lower levels are compounded when regions must await completed expenditure reports for all recipient districts of zones before submitting a consolidated report to the federal Ministry of Health.

In **Ethiopia**, regional health bureaus report that funds arrive in a non-periodic manner, making it difficult to integrate GAVI HSS activities into other health system strengthening work. Lack of capacity and human resources to complete expenditure reporting can further impede the flow of funds. When those reports are delayed in their transmittal from zones to regions and back to the FMOH, disbursements from the central levels will be further delayed.

In **Nepal**, lengthy delays are encountered in the process of approvals and transfers between the Ministry of Finance and the Ministry of Health. The most notable bottleneck found in Nepal relates to financial flows between national and sub-national levels, which are bound by rigorous and rigid rules.

D. Monitoring and evaluation

GAVI advises countries to carefully choose indicators that demonstrate the outputs, outcomes and impact of their GAVI HSS investments. Actual practice seems to depart from that guidance, with countries including indicators in their applications that are not ready for use. Countries do best in identifying outcome and impact indicators that are drawn from standardized, regularly available sources, including household surveys and health information systems. At the level of impact/outcomes, the indicators reported to GAVI are largely consistent with those used to monitor national health strategies.

Conversely, there appears to be insufficient planning and resources devoted to collecting and analyzing output-level data. Output measures represent the changes in service availability, accessibility and quality that result from the types of investments made through GAVI HSS funding (e.g., human resources for health; supplies, equipment and infrastructure; and management and organization). In accepted frameworks for HSS monitoring and evaluation, output measures are critical to fully examine and explain the linkage with HSS input indicators (activities and processes) and its desired outcomes (e.g., DTP3 coverage and child mortality). The lack of output information—describing tangible improvements in the performance of health systems—is not specific to the GAVI HSS grants. In fact, the paucity of such information is a widely occurring problem and a challenge to HSS efforts in many countries[13].

[13] A common framework for monitoring performance and evaluation of the scale-up for better health. Monitoring and Evaluation Working Group. International Health Partnership. February 2008.

In reference to Figure IV.4, countries do well in identifying and reporting on inputs and processes (two columns on the left). In addition, among these six countries, outcome and impact indicators are also widely reported and available (two right-side columns). It is in regards to the output column (with sub-headings for health systems strengthened and improved services) that countries fall short. Although five of the six country proposals include appropriate output indicators (access, use, quality), the information to construct them is not routinely collected. This gap results in an inability to fully describe the sequence of activities and interim (outputs) and longer-term results (outcomes/impacts), as was intended in the HSS framework.

Table IV.4 Types of Indicators included in GAVI HSS proposal

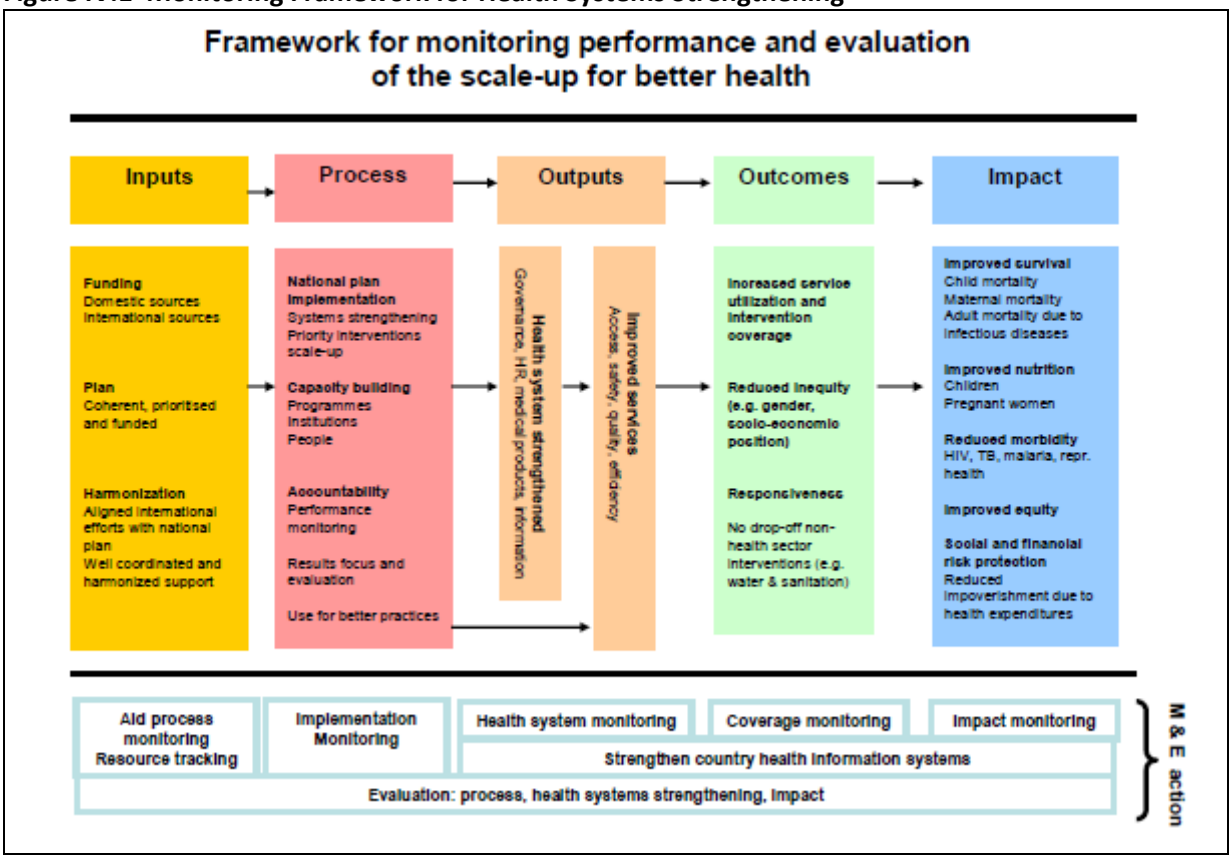
Country	Indicator type		
	Input and activity	Outputs	Outcomes
DR Congo	4	2	3
Ethiopia	18	10	9
Kyrgyz Rep.	9	5	5
Nepal	0	5	6
Vietnam	15	4	9
Zambia	6	0	6

In several countries, the lack of available indicators may be related to the wide-scale redesign of the facility-based health information system (e.g., Ethiopia and Zambia). Consistent with GAVI guidance, five of the study countries are investing GAVI HSS funds to strengthen the national health information systems (i.e., Ethiopia, DR Congo, Kyrgyz Republic, Nepal, Vietnam). In the absence of existing systems to capture HSS variables of interest, many countries may resort to specialized data collection activities for this purpose.

Countries vary in their use of existing monitoring frameworks and inclusion of indicators drawn from the national health strategy or plan. Positive examples come from countries, including DR Congo, where monitoring tools and indicators are selected from those provided in the Interim 2007-2009 HSS Plan. The intention is that, by using these measures (which will be available for all health zones and the targeted health zones), it will be possible to monitor the relative effects of GAVI HSS funding. In some countries, the indicators of the national health strategy themselves were under review or in flux, making it difficult for the HSS activities to align (e.g., Ethiopia). In the Kyrgyz Republic, while the HSS indicators are not found in the M&E framework, they will nonetheless be measured by the GAVI HSS-funded program through a follow-up and reporting system.

In two countries (Ethiopia and Nepal), the Study Team compared indicators drawn from (1) the HSS application, (2) the national health sector development strategy, and (3) IHP+ documents. Termed an HSS Indicator Consistency score, this measure compares indicators grouped by level (e.g., the denominator for calculations such as health posts) and defines consistency as two or more sources having the same indicator per level. The method is described further in the Phase 1 Synthesis Report. In both countries, it was found that the greatest consistency appears among population-based indicators (33 percent in Ethiopia and 36 percent in Nepal). This degree of consistency is expected as indicators at this level are well-defined, have common measurement tools and are monitored by global-level inter-agency working groups. After population-based measures, health center-based indicators have the highest degree of consistency in Ethiopia (23 percent), while In Nepal, the HSS grant's output measures have a consistency level of 25 percent with the other sources, largely due to the common use of one indicator related to the percent of districts implementing CB-IMCI.

Figure IV.1 Monitoring Framework for Health Systems Strengthening



Source: A common framework for monitoring performance and evaluation of the scale-up for better health. Monitoring and Evaluation Working Group. International Health Partnership. February 2008.

E. Nature and sources of technical support

For the purposes of this Synthesis Report, technical support is defined broadly as human resource services provided to the MoH and partners to improve health outcomes, including technical support that is short-term for a specific need, long-term partnerships in-country, and technical support provided by local, regional and international consultants, academic groups or health care institutions[14]

Countries report receiving technical advice and support both during HSS proposal planning and implementation from a number of in-country partners. In the proposal development process, most countries depend on technical working groups led by MoH planning unit staff and active engagement of multilateral and bilateral partner staff. The World Health Organization, in particular, has been funded by the GAVI Alliance to support countries with technical assistance. WHO has provided both support from the local WHO representation as well as provided international consultants to support countries during the application process. UNICEF was a highly active and engaged partner in proposal development. Though less visible, bilateral donor agencies and their technical resource projects partnered in proposal preparation. In at least four countries, external consultants were involved in proposal development.

[14] McKinsey and Company Strengthening Technical Support. GAVI Alliance. 2008.

Technical assistance provided during HSS proposal development, as well as during implementation, is summarized in Table IV.5 below.

During implementation, several Tracking Study countries have relied on technical support providers, whose services they have acquired through contracts, to implement elements of their HSS plans. Among these are local organizations involved in integrated management of newborn and child illness (IMNCI) training (pediatric associations in Ethiopia and Nepal, local NGOs in Nepal); bilateral partners (GTZ for construction in Ethiopia); multilateral partners (UNICEF for equipping health posts, setting up and providing maintenance training in Ethiopia); and national consultants for multiple activities in Vietnam.

Table IV.5 Technical Assistance in GAVI HSS Activities, Application and Implementation

COUNTRY	***HSS Application***			***HSS Implementation***			
	In-country multi- and bi-lateral agencies	*External*	*In-country CSOs*	*In-country multi- and bi-lateral agencies*	*External*	*In-country CSOs*	*Other*
Ethiopia	√	√		√		√	
DRC	√		√	√		√	
Kyrgyz Rep.	√			√			
Nepal	√	√	√			√	
Vietnam	√	√					√

The Tracking Study found that countries held a broad and inclusive definition of technical support. Countries participating in the Tracking Study largely considered technical support to include long-term contacted support from a range of in-country partners, notably CSOs and NGOs, to extend the reach of the MOH in implementation (e.g., procurement, transportation and training). Countries also consider the regular contact and support from in-country development partners, notably multilateral and bilateral agencies, as an important source of technical support (e.g., USAID-funded ZdravPlus and Kyrgyz-Swiss Health Reform Support Project in the Kyrgyz Republic). In contrast, there were very few instances of countries seeking short-term, task-specific, external technical assistance during HSS implementation. The types of technical assistance acquired by source and country appear in Table IV.6 below.

Table IV.6 Technical Assistance Used during GAVI HSS Implementation, by Source

Country	Technical assistance performed	Sources
Ethiopia	*Conduct of IMNCI course for health workers; nurses and health officers*	*Ethiopian Pediatric Society*
	Procurement and distribution of health post supply and equipment kits	*UNICEF*
	Upgrading of health stations to health centers	*GTZ*
DRC	*Situation Analysis (health facility census)*	*Kinshasa School of Public Health*
Nepal	*Introduction of CB-IMCI and training of staff in 11 districts*	At central level, Nepal Technical Assistance Group and Nepal Pediatric Association and five NGOs at district/local levels
	Skills upgrading of auxiliary and VHWs	*Reg. Health Training Centers*
Kyrgyz Republic	*Baseline and follow-up surveys to evaluate the impact of economic incentives*	*WHO*
	Assistance in social mobilization; and assistance to VHC to draft proposals for small grants.	*Zdrav Plus (USAID)*
	Linkage of VHC with HSS Technical and Financial Coordinators	*Kyrgyz-Swiss Health Reform Support Project*
Vietnam	*Support to HSS project (training, M&E, project management and procurement of VHW kit).*	*4 national consultants*

Once funded, the forms of technical support described in the proposals are not uniformly utilized, leading to a question of the real need for the types of support specified in the proposal. The types of technical assistance identified in the HSS proposal and status appear in Annex VI.

In general, the Tracking Study countries are relying on longer term, locally available sources of technical support rather than choosing to acquire short-term external assistance. This use of local resources from CSOs and NGOs to support implementation can be seen in two countries: Nepal and DR Congo, where NGO/PVO participation in the HSS application was substantial.

In Nepal, meetings were held in each of the five regions and attended by the district health office, local and international NGOs, local government leaders, and health workers. These meetings were also attended by a central-level MOH and external development partners. The regional meetings allowed participants at the district level to discuss gaps and needs for additional assistance and served as an integral part of the application planning process. Notably, while NGOs participated in the initial regional meetings, there appeared to be little involvement or consultation at the central level.

In DR Congo, where PVOs/NGOs are principal providers of health services in the absence of a well-functioning government system, local NGO umbrella organizations and international NGOs were involved in HSS application development. As part of the application preparation, civil society

organizations and their level of support for health zones were mapped out[15]. Through this involvement, other NGOs/PVOs were made aware of the CSO funding window and joined a partnership in that application. The HSS funds for targeted health zones will be channeled through contracts with NGOs, which will coordinate the use of the funds and the implementation.

V. Conclusions and Recommendations

The conclusions and recommendations below are based upon information gathered through primary data collection in the six Tracking Study countries. Recommendations were discussed and adjusted by the Tracking Study team and participants for the six countries, including local research teams and government officials, during a three-day Multi-Country Workshop held in Stockholm, September 15-17, 2009.

In addition to these synthesized recommendations, each country Case Study includes a set of recommendations targeted to a range of audiences and actors. In Annex V, recommendations from the case study countries to country program managers, policy makers and stakeholders are tabulated.

Conclusion #1 – Countries value the multi-year, flexible, country-driven characteristics of GAVI HSS grant funding.

There is unanimous agreement among countries that GAVI HSS support is highly compatible and aligned with country policies, plans and programs. Within countries, development partners were consistently positive about the processes through which GAVI HSS was sought and the use of those funds. Across the board, all countries uniformly encourage GAVI to continue providing this type of support while also taking steps to improve it.

Several of the HSS Tracking Study countries are completing their initial HSS grants and either plan to reapply (e.g., Ethiopia) or have recently reapplied (e.g., Nepal) for a second round of funding. All six of the tracking study countries expressed appreciation for the multi-year, flexible funding that the GAVI Alliance has provided and for GAVI's willingness to support country health plans instead of introducing its own priorities. The GAVI Alliance can take steps to improve HSS performance by further pushing alignment and harmonization principles into practice.

Recommendations from Conclusion #1

- GAVI HSS grants should continue with the same principles with improvements based on experience to date, and other global actors involved in HSS might consider following suit.
  GAVI Alliance should increase its alignment with national planning and budgeting cycles, harmonize its reporting requirements with those of other donors, ensure more consistent communications with countries and stakeholders (particularly about GAVI HSS applications and review processes), and increase its own involvement in coordination mechanisms such as Joint

[15] While an innovative approach, the mapping is constrained by a lack of information on the type of support being provided or established criteria or standards for the basic set of support which should be provided.

Annual Reviews at the country level. Each of these recommendations to the GAVI Alliance is discussed in greater detail in the points below.

Conclusion #2 – Aligning GAVI HSS with health sector plans and processes facilitates start up, implementation and monitoring and evaluation.

The alignment of a country's GAVI HSS grant with its national health plan appears to have a very positive effect on start-up and implementation. This is true whether a national plan is already being implemented and a country's GAVI HSS grant is picking up a piece of that larger plan or the funds are used in a "project" mode that complements other HSS initiatives in the country.

Nepal and Ethiopia are the best examples of this phenomenon among the six tracking study countries. Ethiopia's GAVI HSS plan was approved as the country's third Health Strategy Development Program (HSDP-III) and intended to support the Government of Ethiopia's training of the new cadre of 30,000 community-based Health Extension Workers (HEWs), which was underway when the first tranche of GAVI HSS was received. Moreover, the HSS grant proposal incorporated many of the same planning assumptions and analyses that went into the development of the HSDP-II. This degree of alignment, along with the use of existing mechanisms for large-scale equipment procurement and distribution and construction, allowed for rapid absorption of the funds.

Nepal's experience, once its proposal was approved, was similar. The Ministry of Health was in the third year of a five-year health sector plan and had already targeted specific districts for attention. In addition, it was already working with and through the NGO community to conduct many of its training courses, including the IMCI training called for in the GAVI HSS plan. As in Ethiopia, this allowed the government to move quickly during start-up, more quickly than in other countries where the agreements and mechanisms to permit implementation were not yet in place. Countries appreciate the fact that GAVI encourages the use of government systems and procedures.

Conclusion #3 – The management models employed across the six countries varied in their ability to meet the needs of HSS implementation. However, in only one case was management a major impediment to implementation.

Management responsibility for GAVI HSS implementation is either given to health planning and policy divisions or to child or maternal child health divisions. In two of the six Tracking Study countries, special program management units either were or are being created to administer GAVI HSS funding (Vietnam and DR Congo). These project management units are closely linked to the MOH planning unit. In three other countries, management responsibility was with the planning division and one or more people designated as GAVI HSS focal points. In only one country (Zambia) did the management responsibility reside with the child health unit.

The most notable case of management arrangements affecting implementation comes from DR Congo. The human resources required to manage and coordinate the funds were not in place when HSS funds were received. Indeed, in the 17 months since the first disbursement of HSS funds, activities have revolved around the creation of the structures needed to provide oversight and financial accountability in the form of a Project Management Unit and a fiduciary agent. Actual implementation of the planned activities to strengthen service delivery in the health zones has been significantly delayed. In other cases, the human resources devoted to HSS grant management in Vietnam seemed large in comparison

to the size of the grant and the experience of other countries. In Ethiopia, additional program management support would have helped regions struggling with expense reporting earlier than it occurred.

Recommendations from Conclusions #2 and #3

- The GAVI policy to align HSS grants with national health plans has a positive effect on implementation and should continue to be required and strengthened where possible.

- Many countries conducted a situational assessment as part of the process for health systems strengthening support. These assessments should examine and/or further examine the country's capacity to both financially and programmatically implement HSS funding prior to preparation of a GAVI HSS proposal. This step is particularly important in the case of larger grants with implementation at scale. If this has not been done prior to proposal submission, then a situational assessment of readiness to implement must be conducted upon approval of the grant but prior to disbursement of funds.

Conclusion #4 – High-level leadership and health sector coordination, while important for successful application and design, are not enough.

All six countries have high-level HSCC equivalents, chaired by Ministers of Health that meet at least once or twice a year. Each of the six has a operations and/or technical coordination arm or working group that takes direct responsibility for proposal development, supports implementation, and reviews and approves the annual progress reports to the GAVI Alliance (APR). Representation of sub-national levels of government and CSOs is less consistent in the HSCCs and technical working groups. In several cases, similar coordination structures have been created at the sub-national level.

The HSCCs (or equivalent) that oversee GAVI HSS support in all countries are high-level bodies, chaired by Ministers of Health. Four of the six HSCCs in Tracking Study countries existed before the advent of GAVI HSS; in two cases, the body was formed explicitly to oversee the GAVI HSS grant process (Nepal) or used the GAVI HSS as an opportunity to create an overall HSS coordinating body (DR Congo). Although these high-level bodies meet only once or twice a year, their designated technical arms or working groups—which include representatives from the MoH, multilaterals and bilateral agencies and projects—meet as often as twice a month in several of the countries. Only one HSCC in this study had representation from the sub-national level.

Conclusion #5 - NGOs/CSOs are implementing specific GAVI HSS-funded activities in several countries and helping to speed up implementation, but they are not always involved in GAVI HSS design or oversight.

While NGOs/CSOs may sit on national HSCCs and/or their technical working groups, with few exceptions they did not actively participate in GAVI HSS proposal development. While NGOs/CSOs are not at the table in most countries when GAVI HSS applications are made, they are engaged and often contracted to carry out specific activities funded with GAVI HSS support. In DR Congo, NGOs are contracted by the MOH to support service delivery and develop capacity of the MoH for both service delivery and management of specific health zones. In Nepal, the MOH supports the NGOs in GAVI HSS-supported and other districts to conduct the IMCI training that is a key element of that country's GAVI HSS plan. Likewise in Ethiopia, the MoH is contracting with the Ethiopian Pediatrics Association to carry out IMCI

training for health workers and supervisors. In the Kyrgyz Republic, NGOs and community-based organizations are also sub-recipients of GAVI HSS funding. The rationale for not including NGO/CSOs in actual GAVI HSS planning was different for each country.

Recommendations from Conclusions #4 and #5

- Ministries of Health, as the public sector entities leading the planning and implementation processes, should make more concerted efforts to inform and engage stakeholders outside the central MoH in both planning and implementing GAVI HSS, including NGOs/CSOs and sub-national health offices.
- The GAVI Alliance should recognize the gap between its stated principle (i.e. *Government entities, partners, civil society, and the private sector should all be informed and involved, as appropriate, in the planning, implementation and evaluation stages*) and practice in countries. At a minimum, the GAVI Alliance and its partners in-country should inform and engage stakeholders outside the central MoH and encourage their involvement in the planning and design of GAVI HSS applications—creating awareness about GAVI HSS would ensure greater transparency and accountability.
- Ministries of Health, the GAVI Alliance and their in-country partners, and all multilateral and bilateral partners working in HSS should encourage NGOs/CSOs to be proactive in the health sector development process.

Conclusion #6 – Substantial delays in implementation are experienced when the necessary financial systems/arrangements are not in place at the time of GAVI Alliance approval.

Grants held in government bank accounts or by intermediaries (partners, fiduciary agents) are subject to fluctuating exchange rates and devaluation. Zambia, Nepal, and Ethiopia used existing accounts and accounting procedures to transfer GAVI HSS to sub-national levels and to reconcile expenditure accounts. Albeit with differing causes and to varying degrees, DR Congo, the Kyrgyz Republic and Vietnam experienced delayed implementation because the necessary fiduciary arrangements were not in place to receive and/or manage GAVI HSS funding when it arrived. While the underlying reasons differ, the delay in implementation and the financial risk are the same. DR Congo is in the process of consolidating and establishing a MoH financial unit. It did not have the financial systems or agreements in place to administer GAVI grant funding when it arrived. Therefore, 17 months after the first disbursement, only a very small proportion of the available funding has been spent. The Kyrgyz Republic's delay was less—only six months—but still impacted implementation. Due to irregularities in the SWAp account performance and the inability of GAVI HSS funding to enter the pooled funding mechanism, the Kyrgyz Republic established a separate account and put the agreements in place.

Recommendations from Conclusion #6

- The GAVI Alliance and its partners should verify that necessary fiduciary and financial management systems, not just bank accounts, are in place before disbursing significant amounts of HSS funding to a country. Countries that will need to put financial management units in place or to strengthen financial management systems prior to receiving disbursements of funds for HSS implementation should establish realistic timelines for their implementation plans.
- Where financial systems/units are weak or are not already established and functioning, GAVI should employ a two-phased approach. During phase 1, in order to avoid delays in implementation, GAVI would support the country to identify and develop terms of reference,

and hire an outside firm or entity to serve as a fiduciary agency. Once those systems are in place, GAVI would begin to disburse funds for implementation in phase 2. This two-phased approach is a preferred scenario in fragile or post-conflict states or others with weak financial systems (e.g., DR Congo) where little implementation will actually occur under the existing grant timeframe.

Conclusion #7 – GAVI's review, approval and disbursement cycle is out of sync with the annual planning and budgeting cycles in many countries.

A common cause of delayed start-up and implementation is the arrival of GAVI HSS funding outside the established MoH planning and budgeting cycle. On at least one occasion each, Zambia, Nepal and the Kyrgyz Republic[16] reported that they were not able to utilize GAVI HSS funding immediately after its arrival in country accounts because it arrived "off cycle." This had a negative effect on *predictability*, as country planners were either not able to include GAVI HSS as a source of funding in their annual plans because it had not yet arrived, or were not able to use it immediately because it arrived once the annual plan and budget had already been approved. For some countries this appears to be a bigger problem than for others, but it is certainly one of the reasons that Ministries of Health have chosen to manage GAVI HSS funding outside of pooled funding mechanisms, where they exist, and in separate accounts that they can access off cycle when that is necessary.

Recommendations from Conclusion #7

- GAVI should strengthen the predictability of fund disbursements and increase its alignment with the national planning and budget cycles in the countries where it provides HSS funds. The GAVI application/proposal submission, approval, and disbursement processes should be better aligned and synchronized with country planning and budgeting cycles and with fiscal year requirements in order to avoid delays and thereby strengthen the predictability of arrival of funding. Likewise, alignment of GAVI's disbursement of funds with the planning and budgeting cycles of the individual countries would facilitate efficient spending of resources.
- Countries should be fully and routinely informed about the expected duration of proposal submission, IRC review, board approvals and disbursements so that they can plan more effectively for the actual receipt of funds.
- GAVI Alliance participation in country coordination processes, such as Joint Annual Reviews, should be strengthened with the intention of formally entering into pooled funding mechanisms where they are in place, participating in the Joint Annual Review meetings that are now a feature in many countries, and improving their communication with countries and stakeholders about the GAVI HSS funding window and its requirements.

Conclusion #8 - Country M&E plans in HSS applications often include appropriate input and outcome indicators, but they generally lack output indicators as well as the means to measure such indicators on a regular basis.

In accepted frameworks for HSS monitoring and evaluation, output measures are critical to fully examine and explain the linkage with HSS input indicators (activities and processes) and its desired

[16] Country personnel often refer to the late or delayed receipt of funds from GAVI. In fact, after Board approval, the first disbursement of funds occurs, on average, in 16 weeks. For country managers, the pressure arises not so much form "late" arrival as from receipt which is "off-cycle" or not fully predictable.

outcomes (e.g., DTP3 coverage and child mortality). Output measures represent the tangible changes in service availability, accessibility and quality that result from the types of investments made through GAVI HSS funding (i.e., human resources for health; supplies, equipment and infrastructure; and management and organization). Although several of the six country proposals include appropriate output indicators (access, use, quality), the information to construct them is not routinely collected.

Recommendations from Conclusion #8

GAVI and other donors should:

- Work with governments to harmonize their M&E requirements, align them with country-specific indicators and agree on a common reporting format and frequency to reduce the burden on countries. Agreement on a common monitoring framework and indicators is best done during the creation of the national health sector strategy and then reinforced throughout its implementation.
- Continue to provide funding through the GAVI HSS grants to strengthen health management information systems.
- Strongly encourage countries to define appropriate HSS indicators and to more fully substantiate indicator definitions, data collection mechanisms and frequency of collection in the application.
- Recognize that few countries will submit a fully operational M&E plan in the application. Consider a two-stage approach to country M&E planning, with the first step being submission and approval of an illustrative M&E plan with the HSS application and the second being development of a final M&E plan—detailing indicators, methods, processes and costs—after the application is approved. GAVI, along with other global actors in HSS funding, should provide technical assistance if required.
- Participate in multi-partner Joint Annual Review processes in countries and accept the reports from these reviews in place of a separate annual reporting requirement.

Conclusion #9 – There have been multiple revisions of the GAVI HSS application guidelines and some inconsistencies in messages between the GAVI Alliance and some of the HSS-recipient countries, including criteria for IRC review of applications.

HSS Tracking Study countries have different understandings, perceptions and experiences when it comes to how they may use GAVI HSS support. Countries held differing perceptions of whether the reprogramming of their activities required GAVI Secretariat approval or whether GAVI could simply be informed after the HSCC (or its designee) had approved such changes. It was further unclear as to whether such approval/information could be passed only through the Annual Progress Report or could be sought at other points during the year through more regular communications.

In other cases, countries interpreted the guidelines as to whether they were able to reprogram or reallocate funds to different activities within those stipulated in their application. Countries clearly had differing experiences in regards to reprogramming/reallocating of HSS grant monies. There was a particular lack of clarity as to the funding of recurrent costs such as salary supplements/top-offs or supervision costs. Some countries understood that they had the flexibility within their grants to fund such activities while others understood that they were not permitted to do so.

Recommendations from Conclusion #9

GAVI should:

- Provide clear and consistent guidelines to countries on how GAVI HSS may be spent, including re-allocation/re-programming of funds and use of funding for recurrent costs such as salaries.
- Base its decisions on objective criteria, a proposal review checklist and scoring system that can then be shared with the country.
- Provide more guidance on how the GAVI HSS principles can be made operational. Clarify what, if any, role those principles will play in the evaluation of GAVI HSS funding.

Make the IRC feedback on proposals more substantial, with clear explanations as to where and how proposal elements fall short.

Conclusion #10 – Frequently, countries underestimate the time needed to prepare for grant implementation, including the time needed for curriculum development for training activities, establishment of procurement mechanisms and agreements, etc.

Conclusion #11 - Countries are using a variety of procurement mechanisms and agents—both governmental and non-governmental—to speed up the implementation of GAVI HSS.

Procurement of goods and services can be a lengthy process with difficulty not only in efficiency of purchasing but also in terms of transparency and accountability for use of funds. Each country has experienced some implementation delay due to the procurement process, although the procurement timeframes experienced were consistent with country experiences. This suggests that HSS proposal work plans underestimate the amount of time required for the procurement process, thereby creating an almost "built-in" risk of implementation delay. In some cases, actual procurements were contingent on the creation of new national structures and mechanisms for procurement—again an inherent risk in a time-limited implementation.

The Tracking Study countries used a variety of government and non-governmental procurement mechanisms. Ethiopia and DR Congo contracted out to different development partners (UNICEF, GTZ, UNOPS) while the Kyrgyz Republic, Nepal and Zambia worked through the existing government procurement units. All of the procurement methods employed were consistent with country precedent, but not all were carried out by MoH procurement units. In Ethiopia, an important indicator of continued performance will come with the transition to a newly created FMOH Pharmaceutical Fund and Supply Agency. While UNICEF has procured and distributed equipment kits for health posts, this agency will be responsible for equipping 300 health centers, an activity which was expected to be implemented over the four-year grant life cycle.

Recommendations from Conclusions #10 and #11

- Countries should assess risks and more accurately estimate timelines for pre-implementation start-up activities, such as curriculum development and establishment of procurement procedures and mechanisms, in proposal development and during HSS start-up and build their timelines accordingly.

- GAVI and other stakeholders should encourage countries to continue striking a balance between efficiency (contracting out for procurement) and using GAVI HSS to build their ministries' own procurement capacity (managing GAVI HSS-related procurement directly).

Conclusion #12 - Countries tap into a wide range of technical assistance options that are not always reflected in discussions at the global level.

Countries report receiving technical advice and support both during HSS proposal planning and implementation from a number of in-country partners. In the proposal development process, most countries depend on technical working groups led by MoH planning unit staff and active engagement of multilateral and bilateral partner staff. The World Health Organization, in particular, has been funded by the GAVI Alliance to support countries with technical assistance. WHO has provided both support from the local WHO representation as well as provided international consultants to support countries during the application process. UNICEF was a highly active and engaged partner in proposal development. In at least four countries, external consultants were involved in proposal development.

Once funded, the forms of technical support described in the proposals are not uniformly utilized, leading to a question of the real need for the types of support specified in the proposal.

The Tracking Study found that countries held a broad and inclusive definition of technical support. Countries participating in the Tracking Study largely considered technical support to include long-term contacted support from a range of in-country partners, notably CSOs and NGOs, to extend the reach of the MoH in implementation (e.g., procurement, transportation and training). Countries also consider the regular contact and support from in-country development partners, notably multilateral and bilateral agencies, as an important source of technical support. In contrast, there were very few instances of countries seeking short-term, task-specific, external technical assistance during HSS implementation.

Recommendations from Conclusion #12

- GAVI should broaden its definition of technical support to be more in line with country definitions and use.
- Countries should periodically update their technical support needs/plans throughout the life cycle of the grant and take steps to access either local or external technical expertise, if needed. For example, joint annual review processes can serve as an opportunity to identify barriers to implementation and any associated technical assistance needs.
  The GAVI Alliance should encourage countries to seek technical support in areas that the Tracking Study identified as weaknesses and implementation bottlenecks, notably HSS monitoring and evaluation and financial management systems.

Conclusion #13 – There is a demand from countries for more information about experiences and lessons learned by other countries with GAVI HSS.

The Multi-Country Workshop provided countries with an opportunity to present and discuss the status of implementation as well as bottlenecks experienced and solutions sought. These exchanges were rich and detailed and brought to the fore areas of important convergence and divergence. Participants cited the workshop as a valuable opportunity to learn from others how proposals were developed, obtain ideas for improving implementation, and obtain feedback and clarifications from the GAVI Alliance. In

the self-assessment, respondents were unanimous in their opinion that the Tracking Study overall had facilitated cross-country learning and capacity-building.

In contrast, the electronic exchange of information (e-forums) on Technical Assistance and Financial Management mechanisms which took place prior to the Multi-Country Workshop brought little participation.

Recommendations from Conclusion #13

- The GAVI Alliance should strengthen its mechanisms for information sharing and dissemination of experiences in application, implementation and M&E.
- A range of mechanisms for engagement and information sharing should be examined. For the early years of HSS implementation, it may be necessary to convene physical meetings to help germinate a "community of practice" around these issues.

Conclusion #14 – GAVI HSS can be an important catalyst for the creation and/or use of pooled funding mechanisms. At the same time, GAVI HSS is not always a good fit because the regulations governing pooled funding and GAVI's own requirements make pooling difficult.

Countries appreciate GAVI help in promoting the pooling of donor funding to avoid duplication and also achieve greater results. GAVI HSS funding was the first to be managed through a newly established pooled funding mechanism in Ethiopia. Because of the ground-breaking and positive experience, the Government of Ethiopia and other donors have prepared a joint financing arrangement through which additional donors will pool their funding in the same FMOH-managed account. Three other countries with SWAps and pooled funding mechanisms chose not to manage their GAVI HSS funds in accordance with the SWAp mechanism but to channel the HSS funds through a separate and non-pooled account. Countries cite the need to link and report on their HSS support for specific types of activities and results as the primary barrier to including these funds in pooled funding mechanisms.

Countries with SWAp mechanisms encouraged the GAVI Alliance and other donors and stakeholders to participate in the SWAp coordination group and to contribute to unified health sector plans so as to avoid duplication and not impose additional recording/reporting requirements. At least two SWAp countries, Ethiopia and the Kyrgyzstan, would like the GAVI Alliance to participate in the pooled funding mechanism.

Recommendations from Conclusion #14

The GAVI Alliance should recognize the gap between its stated principle (i.e. *HSS support should be in line with government management systems and financial management procedures)* and the practical obstacles that prevent countries from doing so. In the context of pooled funding mechanisms, clarification of GAVI's need to have HSS-fund specific financial and results reporting is required. The GAVI Alliance, together with donors and other in-country stakeholders, should work together to negotiate and contribute their share to the country's health sector development to fill gaps instead of duplicating, causing system fragmentation and disrupting on-going efforts.

VI. Annexes

ANNEX I - COUNTRY RESEARCH PARTNERS

Country	Institution	Researcher
Zambia	University of Zambia, Department of Economics	Prof Dick Jonsson
		Dr. Pamela Nakamba Kabaso
		Mr Abson Chompolola
		Mr Maximilian Mainza
		Ms Lilian M Sinyangwe
	Consultant	Dr Cosmas Musumali
Vietnam	Hanoi Medical University	Nguyen Thi Kim Chuc
		Tran Khanh Toan
Nepal	Center for Health Policy Research and Dialogue (CHPRD)	Dr. Suniti Acharya
		Mr. Pushkar Raj Silwal
		Ms. Reena Thapa
	Consultants	Prof. Dr. Shib Bahadur Karkee
		Mr. Bijay Bharati
		Mr. Shyam Nepal
Ethiopia	Addis Continental Institute of Public Health	Yemane Berhane, MD, MPH, PhD
		Asmeret Moges Mehari
		Dr. Belaineh Girma
Kyrgyz Republic	Health Policy Analysis Unit , Centre of Health System Development (CHSD)	Baktygul Akkazieva
		Arnol Samiev
		Adyljan Temirov
Democratic Republic of the Congo	Ecole de Santé Publique, Faculté de Médecine, Université de Kinshasa	Patrick Kalambayi Kayembe, MD, PhD, MPH
		Jean Nyandwe Kyloka

ANNEX II - HSS TRACKING STUDY PHASE 2 METHODS, BY COUNTRY

Nepal: Qualitative data were collected through key informant interviews with the chief/in-charges of the health institutions at central, regional, district and health facility levels. These semi-structured interviews focused on the implementation experiences in regard to the GAVI HSS activities. A standard interview guide was tailored to the various groups e.g. HSCC members, policy makers at central level of Ministry(ies) of Health and Finance, divisional directors, focal persons, directors of training centers were used. A total of 26 persons at central level, regional level and at district level were interviewed. Quantitative data regarding implementation of the GAVI HSS activities were also collected from secondary sources as well as field visit. Major data sources used for the quantitative parts of the study included policy and program level documents of the Government, donor documents, previous review reports, the source book of the Ministry of Finance, annual work plans, and budgets of the divisions and centers of the Department of Health Services (DoHS), and HMIS.

Field visits were conducted to supplement the information obtained from document review and interviews and to verify the implementation of activities. Four districts were selected for the tracking study as follows: Sarlahi, Rupandehi, Darchula and Sundhupalchowk. Two rounds of field visits were conducted (February and April 2009). The criteria for selection of districts for field visit include a combination of low and high performing districts as per government rating, feasibility of access from the perspective of seasonal variation, districts having representative population size and representative of all geographical regions.

Zambia: Data collection involved document review and key informant interviews with Ministry of Health officials, representatives of cooperating partners and other major stakeholders, officers at the provincial and district health offices, in health facilities. Across these levels, 57 health professionals were interviewed. Focus group discussions were held with neighborhood health committees. Data at each level was collected using an interview guide.

In addition to the interviews, an Indicator Tracking Sheet was also used. The tracking sheet was developed to allow on-going recording of progress towards the HSS activities' outputs, outcomes and impact. The tracking sheet was administered at health centre level and corroborated at district office level.

The study sample comprised four provinces that were selected purposively (based on easy of access and level of implementation) and these included the Copperbelt, Eastern, Western, and Luapula provinces. Out of the twelve GAVI HSS beneficiary districts, seven were sampled for the study. In each district, two health centers and two neighborhood health committees or community health workers were randomly sampled for the study. A total of 15 heath centers and 22 neighborhood committees were selected.

Vietnam: The study methods included key informants interviews with (a) directors of the concerned central level government organizations and in-charges at the provincial level; (b) staff at district and community level health facilities and training institutions; and (c) village health volunteers trained. Across levels, over 55 health professionals were interviewed. In addition, the study conducted an extensive review of documents include (a) program plan and implementation documents related to the activities; (b) existing monitoring and supervision systems and tools at central, provincial and district level; and (c) training material developed and/or used and resources for supervision. Structured observations were made of the activity implementation. Data collection sources include Central level

institutions, Provincial Health Offices, Secondary medical Schools or Medical College at the selected provinces, District Public Health Offices and Commune Health Centers.

In-depth implementation tracking was conducted in three of the ten target provinces, Hatay, Binh Dinh, and Tra Vinh. Within these districts two communes were purposively selected with the assistance of provincial and district health authorities as high, middle, and/or lower-performing communes with respect to GAVI HSS implementation.

DRC: Methods used in the Tracking Study included the collection of both qualitative and quantitative information to track the implementation of HSS activities. Study activities were initiated with two visits from members of the core Study Team to orient partners on study protocols and procedures and to generate operational details for the full implementation of the study (December 2008 and March 2009). Beginning in March 2009, the School of Public Health conducted individual and group interviews, reviewed documentation and visited three HSS target provinces and select Health Zones (up to 13) to verify data and guide indicator selection and prioritization. The study team worked closely with Ministry of Health staff responsible for the GAVI HSS activities to determine data availability and to assess the existing system for analyzing and presenting the data for HSS reporting. An HSS indicator tracking tool, linked to the HSS proposal indicators, was developed to assist the MOH in monitoring at central, provincial and healthy zone levels.

Kyrgyz Republic: The study used both qualitative and quantitative methods to obtain comprehensive information about HSS proposal development and early implementation experience. Methods included in- depth interviews to (a) assess proposal development using a standard Tracking Study Interview Guideline that was adapted to the Kyrgyz context and to (b) analyze early implementation, using three questionnaires targeted towards individuals responsible for HSS management and implementation at the national, oblast and rayon levels. These questionnaires, developed by the research team, were semi-structured containing open- and closed-ended questions. The questionnaires were piloted and then administered. In addition, document reviews were carried out on national, regional and district financial and programmatic reports. These materials provided detailed implementation level information on financial flows and management practice as well as technical achievements.

Data sources included institutions and individuals that receive resources under GAVI HSS, administer and/or coordinate those resources or provide input to activities of the GAVI HSS components. In total about 30 individual and group interviews were carried out across the country. Three oblasts and rayons were purposively selected for inclusion in the study. Criteria for selection included distance from the capital, Bishkek (some close and others remote) and rayon-level implementation of specific components of the GAVI HSS grant, notably an economic incentive pilot for primary care staff.

Ethiopia: In Phase 2, a range of qualitative and quantitative study methods were utilized. Prior to data collection, study team leaders visited each region to explain the study's purpose and select study sites. A team of three experts collected data in each study unit, using document and record reviews, interviews of key informants, and observation of health facilities. The team spent one week in each selected woreda. Across the three regions, 43 individuals at various levels were interviewed. Facility observations were conducted in 6 health centers and 20 health posts.

Given the time and resources available, three regions and two woredas within each region were selected as primary study areas, purposively using regional-level selection criteria, including population size, GAVI HSS funding amounts, and absorption and liquidation capacity. The Amhara and Oromia regions were selected based on population size and significant funding received from the HSS GAVI.

Afar was selected as representative of the emerging regions and for its role in the construction of health posts using GAVI-HSS funding.

In each region, the ACIPH research team, together with experts from the region, selected zones and woredas using criteria described in the Case Study. In each woreda, the main health center and its satellite health posts were included in the study. The team spent one week in each selected woreda. Across the three regions, 43 individuals at various levels were interviewed. Facility observations were conducted in 6 health centers and 20 health posts. The field work was conducted from mid-April to mid-May 2009.

ANNEX III - INDIVIDUALS INTERVIEWED, BY COUNTRY

Nepal

Name	Position/Title	Organization
Dr. Padam Bahadur Chand	Chief, Public Health Supervision, Monitoring and Evaluation Division	MoHP
Dr. Mingmar Sherpa	Director, Logistics Management Division	LMD, DoHS
Mr. Krishna Bahadur Chand	Chief, Expanded Program on Immunization	EPI, CHD
Dr. Bhim Acharya	Chief, CB-IMCI Unit	CHD, DoHS
Mr. Ghana Shyam Pokharel	Chief, Planning Unit, MD, DoHS, Focal person for construction of the birthing center	MD, DoHS
Ms. Rita Subedi Joshi	Focal Person for HFMOC training, MD	MD, DoHS
Mr. Rishi Khadka	Focal Person, AHW and VHW Training Activity	NHTC, DoHS
Mr. Anil Thapa	Public Health Officer, Health Management Information System Unit, Management Division	MD, DoHS
Mr. Susheel Lekhak	GAVI HSS, Focal Person for HMIS	MD, DoHS
Mr. Ram Sundar Yadav	GAVI HSS, Focal Person for LMD	LMD, DoHS
Mr. Krishna Bhatta	Chief, Regional Health Training Center, Dhangadi	RHTC
Mr. Krishna Karki	Co-ordinator, AHW Training Program, Dhangadi	RHTC
Mr. Parmananda Joshi	Co-ordinator, VHW training, Dhangadi	RHTC
Dr. Rajendra Raj Pant	Chief, District Health Office, Sindhupalchowk	DHO
Dr. Hemanta Ojha	Chief, District Health Office, Darchula	DHO
Mr. Narendra Joshi	Focal Person, CB-IMCI	DHO
Mr. Narendra Badhu	Focal Person, HFMOC	DHO
Mr. Arun Kumar Jha	Chief, District Public Health Office, Sarlahi	DHO
Dr. M. Maskey	Chairman	Nepal Health Research Council

Ms. Anne M. Peniston	Director	Office of Health and Family Planning, USAID
Dharmapal P. Raman	Health Program Management Specialist	Office of Health and Family Planning, USAID
Dr. Sudha Sharma	Secretary	MoHP
Dr. M.G. Sherpa	Director	Logistics Management Division, MoHP
Mr. Kedar Paneru	Undersecretary	Ministry of Finance, Health and Population Section
Dr. Robert Timmons	Team Leader	Health Sector Reforms Program, RTI
Ms. Susan Clapham		DFID
Dr. Neupeme	Department of Public Health Officer, Bhaktapur	
Dr. Tika Man Vaidya	District Governor	Rotary Club
Dr. B.K. Suvedi	Director	Family Health Division, MoHP
Dr. Shambhu Sharan Tiwari	Director	Management Division, MoHP
Dr. Nastu P. Sharma	Health Section Chief	World Bank
Dr. K.B. Gharti	In-country Immunization Officer	GAVI
Dr. Jeffrey M. Partridge		EPI, WHO
Dr. Alexander Andjaparidze	Representative and Chief of Mission	WHO
Ms. Sara Nyanti	Chief of Health Section	UNICEF

Vietnam

Name	Position/Title	Organization
Duong Huy Lieu, MDr, PhD	Director of Planning and Finance Director of PMU	Department of Planning and Finance
Nguyen Hoang Long	Vice Director of Planning and Financing Dept PMU member	Department of Planning and Finance
Dr. Pham Van Tac	Vice Director of Personal and Organization Dept.	Personnel Organization Department-Ministry of Health
Truong Viet Dung	Director of Research and Training Dept.	Research and Training Department
Hoang Thi Giang	Chief accountant of the project	Planning and Finance Department
Duong Duc Thien, MPH	Secretary	Health Policy Unit
Vu Van Chinh	Program Officer PMU member	Personnel Organization Department-Ministry of Health
Duong Thu Hang	PMU member	
Dinh Thanh Thuy	Accountancy of the project	
Le Thi Thuy An	PMU member	
Nguyen Tran Hien	Director of NIHE	NIHE
Nguyen Tuong Son	Vice Director	Department of Social, Cultural and labor affairs, Ministry of Planning and Investment
Nong Thi Hong Hanh	Expert	Foreign Economic Relations Department Ministry of Planning and Investment
Hoang Minh Thoa	Vice Director	Department of Finance and Monetary Ministry of Planning and Investment
Vu Thuong	Expert	Department of Finance and Monetary

		Ministry of Planning and Investment
Do Hong Phuong	Health and Nutrition Section	UNICEF, Vietnam
Vu Minh Huong	PATH officer	
Hitoshi Murakami, MD, MPH, PhD	Expert Services Division,	International Medical Center of Japan (formerly WHO officer in Vietnam)
Dr. Lokky Wai	Senior Program Management Officer	WHO, Vietnam
Nguyen Hoang Linh	Manager	Cang Long District Health Center
Duong Thanh Hieu	Vice director	Cang Long District Health Center
Nguyen Van Son	Vice director	Tieu Can District Health Center
Nguyen von Hung	Director of Health Services	
Nguyen Thi Chuc	Vice director	Qui Nhon Health Center
Dao do My	Director	Qui Nhon Health Department
Cao Hoang Mong Tien	Vice director	Tuy Phuoc Health Department
Duong Ngoc Hung	Director	Tuy Phuoc District Health Center
Ho Thi Hue	Specialist for project	
Nguyen Thanh Mai	Chief of Accountancy	Tuy Phuoc District Health Center
Bach Cong Tien	Vice Chairman	Ba Vi District Committee
Nguyen Danh Quang	Director	of BaVi District Health Center
Vo Van Tan		Ba Vi District Health Center
Khuong van Long	Head of Tong Bat CHS	Tong Bat CHS
Phung Van Duc	Head of Thai Hoa CHS	Thai Hoa CHS

Chu Thi Thanh Huong	Immunization Specialist	Thai Hoa CHS
Pham Van Dong	Immunization Specialist	Tong Bat CHS
Nguyen Thi Thanh Chuong	Head of Tan Binh CHS	Tan Binh CHS
Nguyen Thi Tieng	Communization Specialist	Tan Binh CHS
Vo Thi Mong Thu	Head of Cang Long CHS	Cang Long CHS
Nguyen Thi Ngan	Head of Cau Quan CHS	Cau Quan CHS
Tran Thi Hong Hue	Ex-Head of Cau Quan CHS	Cau Quan CHS
Nguyen Van Son	Communization Specialist	Cau Quan CHS
Kim Thi Vi Thy	Accountant	Cau Quan CHS
Dao Thi Huong	Head of Tran Phu CHS	Tran Phu CHS- Qui Nhon
Do Hong Tuan	Head of Ghenh Rang CHS	Ghenh Rang CHS- Qui Nhon
Tran Khanh Ngan	Head of Phuoc Loc CHS	Phuoc Loc CHS- Tuy Phuoc
Nguyen Ngoc Thun	Head of Phuoc An CHS	Phuoc An CHS- Tuy Phuoc

Zambia

Name	Position/Title	Organization
Dr. Penelope Kalesha	Child Health Specialist	Child Health Unit, MOH
Dr. Victor Mukonka	Director	Directorate of Public Health, MOH
Davies Chimfwembe	Director	Directorate of Planning, MOH
Henry Kansembe	Chief Planner	Directorate of Planning, MOH
Alison Nagugwere	Current: Program Manager Prior: Program Officer	Current: Human Resource for Health Initiative, Clinton Foundation Prior: CIDA
Dr. Helen Mutambo	NPO/Immunization	WHO

Kagulura Solomon	NPO/MPN	WHO
Abrahams Mwanamwenge	NPO/Logistics Officer	WHO
Belem Matapo	NPO/Surveillance	WHO
Roy Maswenyeho	Principal Accountant	MOH
Frances Mutumbisha	EPI Logistician	Child Health Unit, MOH
Cosmas M. Musumali	Current: Consultant Prior: Project Director	Prior HSSP (USAID funded TA)
Mr Kenneth Mapane	Head of Procurement	Procurement , MOH
Dr Flint Zulu	EPI Officer	UNICEF
Dr Sitali Mswenga	HIV&AIDS/PMTCT Specialist	UNICEF, Former GAVI consultant
Ms Mary Kaoma	EPI/Community/IMCI Specialist	HSSP (USAID funded TA)

Ethiopia

Name	Position/Title	Organization
Dr. Mekdim Enkossa	Focal Point for GAVI in the FMoH, Planning and Programme Department	PPD – MOH
Dr. Filimona Bisrat	Country Representative	Core Group
Dr Mekonnen	Consultant to the MOH – Disease Prevention and Control	Consultant
Leulseged Ageze Zelelew	Deputy Project Director, health Care Financing/HSR	Abt Associates (Essential Service for Health in Ethiopia)
Alison Forder	Health and HIV AIDS Advisor	DFID
Ms. Tomoyo Miyake	Head of Health Section	JICA
Tesfaye Bulto	ESHE Deputy Director	JSI
Bizuneh Feteneh	Acting Dept Head -- Health Extension Program Center	MOH
Yehwalashet Bekele	Health Extension Department Head	MOH

Teshome Regassa	Health Training Team Leader	MOH
Ato Gaddisa	HMIS	PPD/FMOH
Jan Debyser	Logistics specialist Health Post and Health Center Kit Distribution	UNICEF
Assaye Kassie,	Health Specialist (Child Survival)	UNICEF
Dr. Vivian V. Steirteghem	Deputy Representative	UNICEF
Atakilt Berhe	Health Specialist	UNICEF
Eshete Yilma	Deputy Team Leader Health	USAID, Ethiopia
Mery Sinnitt	Team Leader Health	USAID, Ethiopia
Dr. Nehemie Mbakuliyemo	WHO EPI Team Leader	WHO
Dr Asnakew Yigzaw Tsega	National Program Officer – EPI	WHO
Wendmsy Amregne Mekasha	Economic Analyst	The World Bank
Sunil Rajkumar	Health Economist	The World Bank
Stefano Eliero	Consultant	The World Bank

All 43 individuals interviewed at the sub-national level were provided with assurance of confidentiality. Therefore, no names appear for this group.

Kyrgyz Republic

Name	Position/Title	Organization
Mr. Karataev M.	Deputy Minister	MOH
Mr. Abdikarimov S.	Deputy Minister, Chief State Sanitary Doctor	MOH
Mr. Koshmuratov A.	Head of Department for Strategic Planning and Reform Implementation	MOH
Ms. Nazarova Z.	Head of Economics and Financial Policy Department	MOH
Mr. Elibesov B.	Deputy Minister, General Director of MHIF	MHIF – Mandatory Health Insurance Fund

Ms. Komarevskaya L.	Head of Department for Analysis and Perspective Development	MHIF
Ms. Adjaparova A.	Technical Project Coordinator	Component HSS GAVI – Project Coordination
Kubatova K.	Financial Manager	Component HSS GAVI – Project Coordination
Mr. Kalilov J.	Head	RCI – Republican Centre for Immunoprophylaxis
Ms. Safonova O.	Deputy Head Ms.	RCI
Ms. Aitmurzaeva G.	Director	RCHP – Republican Centre for Health Promotion
Ms. Muzabekova Ch.	Deputy director	RCHP
Ms. Sargaldakova A.	Project Specialist	World Bank
Ms. Imanalieva Ch.	Health Officer	UNICEF
Mr. Moldokulov O.	Head of Country Office	WHO
Ms. Mukeeva S.	Director	FGP Association
Mr. Schüth T.	Director, Chief Project Coordinator	Kyrgyz-Swiss-Swedish Health Project
Mr. Aidaraliev R.	Project Coordinator	Kyrgyz-Swiss-Swedish Health Project
Ms. Sulaimanova A.		Programme ZdravPlus

Democratic Republic of the Congo

Name	Position/Title	Organization
Mr. Stephen Haykin	Mission Director	USAID
Ms. Michelle Russell	HPN Officer	USAID
Mrs. Lina Piri-Piri	Child Survival Specialist	USAID
Dr. Leon Kintaudi	Project Director	Project AXxes (Interfaith Medical Alliance/ ECC/Catholic Relief Services/World Vision

		(USAID project)
Dr. Albert Kalonji	Program Manager	Project AXxes (Interfaith Medical Alliance/ ECC/Catholic Relief Services/World Vision (USAID project)
His Excellency, Dr. Mwami Mopipi Mukulumanya	Minister	Ministry of Health -MOH
Dr. Miakala	Secretary General	MOH
Dr. Kalambay	Director, Department of Studies and Planning	MOH
Dr. Lokadi	Director Department of Primary Health Care	MOH
Dr. Micheline Mabiala Eleyi	EPI Director	MOH
Dr. J.P. Bemanga Nkoto Nombe	Financial and Administrative Manager, EPI	MOH
Mr. Vicki Pena-Ahindu Difumankoy	Database Manager, HMIS	MOH
Mr. Chelo	Director Human Resources Division	MOH
Dr. Matthieu Kamwa	WHO Representative	WHO
Dr. Tsogbe Koffi	Team Leader, EPI Programme	WHO
Ms. Yolande Yasembe	Program Manager, Routine EPI	WHO
Dr. Ncharré Chouaibou	Planning, Monitoring and Evaluation Specialist	WHO
Mr. Jean Pierre Lokonga	Financial Management Specialist	WHO
Dr. Patrick Kalambayi Kayembe	Deputy Director	School of Public Health
Mr. Manolo Demeure	Resident Representative	Belgian Technical Cooperation
Mrs. Fabienne Ladrierre	Studies and Planning Specialist (attached to Studies and Planning Department,	Belgian Technical Cooperation

	MOH)	
Dr. Patrick Mullen,	Economist, East/Central Africa Region	World Bank/Washington Headquarters
Ms. Tomo Morimoto	DRC Specialist/GAVI focal point	World Bank/Washington Headquarters
Ms. Pierrette Vu Thi	Representative	UNICEF
Dr. Célestin Traoré	Health Specialist	UNICEF
Dr. Danuya Granga	EPI Specialist	UNICEF
Dr. Alain Forest	Technical Assistant, HMIS/Ministry of Health	European Union/Health Program ("9ème FED")
Dr. Ambroise Tshimbalanga	President	Rotary Club
His Excellency, Dr. Mashako Mamba	Minister	Ministry of Higher Education
Leon Kitaudi	Project Director	Project AXxes (Interfaith Medical Alliance/ECC/Catholic Relief Services/World Vision
Dr. Mukengeshayi	MOH Cabinet Director	Ministry of Health
Dr. Vital Mondonge Makuma,	Director, Disease Control Department	Ministry of Health
Jean Pierre Noterman	Liaison, Embassy of Belgium with BTC	Belgian Embassy
Dr. Jacques Wangatta	Coordonnateur	PARSS Project
Dr. Mulohwe Micheal Mwana Kasongo		European Union/ Health Program
Marie Jeanne Bokoko		CIDA- Canadian International Development Agency
Silvie Monette		CIDA
Marie Adele		CIDA

Matingu		
Michel Descouens		GTZ
Jean Gikapa	CCM Member	Management Sciences for Health
Dr Manu Burhole	Provincial Medical Officer	Sud Kivu Province
Dr Piko Bokumu	Health Officer, EPI	
Dr Zozo	Health Officer, HMIS	
Dr Bahizire Apollinaire	Health Officer, Research and Planing Unit	
Dr Kulimishi	District health officer	Kalehe District
Mr Saïdi Claude	Health Administrator	
Mr Luambazi Roger	In-Charge Nurse, EPI	
Mr Mituga Aimé	District Health Officer, Nutrition	
Aksanti Birigamine Seraphin	Nurse in General Reference Hospital	
Mulume Sangara Norbert	IT du CS Muhongoza	
Muregwa Oscar	Nursing Officer	
Baseme Karamba		Nursing Office, Mushemi Health Center
Dr Bashwira Furaha	District Health Officer	Kasha District
Mr Yalala Pascal,	District Health Administrator	
Mr Basoda Pascal	Health Officer, Nutrition	
Mr Hababwema Midero Platon	Nurse Supervision, EPI	

Mme Mastaki Cirezi	Chief Nursing Officer	Reference General Hospital
Mr Mapinzi Ngwashi Christophe	Nursing Office, Lumu Health Center	
Mr Hababwema Midero Platon	Nursing Officer ;	
Mr Bwemere Baguma Clovis	IT du CS Nyamuhinga	zone de santé de Bagira – Kasha.
Mr Mukamba Mabunda Alexis	Nursing Officer	Mulongwe health center
Mr Mazongoloko Manie	Nursing Officer	Kirungu Health Center
Mr Zabene Kabwanda	Nursing Officer	Kalundu Health Center
Mr Bahimba Bernard	Senior Nursing Officer	Uvira District
Mr Ndungu Chiyika Olivier	Nursing Officer	Kalundu Regional Health Center
Sr Mulali Laeticia	Nursing Officer	Tanganyika Health Center
Dr Tsasa Louis	(Interim) Provincial Medical Officer	Bas Congo Province
Dr Mabunda Jean Baptiste		Bas Congo Province
Dr Fondane Pierrot	Officer in Charge	Primary Health Care Direction
Madame MASASU FAUSTINE	Administrator	Kinshasa Province Health Inspectorate
Dr MONA	Health Officer	EPI/Kinshsa West (representing Provincial EPI Coordinator)
Dr Pélagie MOHINDA	Medical Health Officer	Kinshasa District Health Management Team

Mme Elisée KALUBI	Administrator	Kinshasa District Health Management Team
Benoît NGOYI	Community Health Worker	Kinshasa District Health Management Team
Alexis MISAMU	Supervisory Nurse	Kinshasa District Health Management Team
NDONGALA KIANZOLANI	Nurse	Shaloom Health Center
MUDIPANU Jeannette	Nurse	Saint Clément Health Center
KASONGO Théo	Nurse	La charité Health Center
KIAMBI Aniece:	Nurse, Clemence Health Center	
Maman Monique	Nurse	Makala Health District
Dr Gustave MUNDU	Medical Officer	Kokolo District
José MILANDU	Supervisor Nurse	Kokolo District
Mme Adarine MAPUMA	Nutritionist	Kokolo District
Lieutenant François KALUILA	Environment Officer	Kokolo District
Lieutenant ILUNGA:	Community Health Worker	Kokolo District
KALUKU DIBONGA:	Pharmacist	Kokolo District
Capitaine Marie Madeleine SONA:	Administrator	Kokolo District
Maman KULU	Chief Nursing Office in Charge of EPI	Kokolo Health Center
Madame TUBASOMBA	Nurse EPI	Kokolo Health Center
Mme VERO MAYINDO	Nurse CS	Kokolo Health Center
MILANDU	Supervisor Nurse	Kokolo Health Center
Mme MWAMBA	Prenatal Program	Kokolo Health Center

Edmond		
Dr Narcisse Embeke (NAIA)	District Medical Officer	Tandala District
Lembunzi Lole ISME		Tandala District
Alphonse Alemba Kozo	IS/ZS	Tandala District
Pelemgamo Saba	DN	Tandala District
Pepo Dikanda	Adminstrator	Tandala District
Samuel IZE – ITINZAGO	Nurse	BONGBIA Tandala Health Center
Gisèle DENAMBILI SAZA	Nurse	Bozombali Health Center
Dr Lucien EKWAKOLA	District Medical Officer	Tandala District
BUNDA EBALE		General Reference Hospital
MOPENDA WA KUKU	Deputy Administrator	
LIKOLO LIKUMBELO	Nurse	KUNGU Pilot Health Center
NTUMBA BOLYIA	Assistant Nurse	BODUBWA Health Center
Dr MIAKASISA MBILU	DMO	Zone de Santé de BUDJALA
MATONDO PHELO		Zone de Santé de BUDJALA
BATEGI BALANDI	Nurse	Zone de Santé de BUDJALA
LONGELE MONYANNYO	Deputy Administrator	Zone de Santé de BUDJALA
KPADO TOTEANAGO	DN	Zone de Santé de BUDJALA
Joël MANA LEKANDELO	Nurse	EVECHE/BUDJALA Health Center
Jonas MUKAMBA DENDELE	Nurse	NZEKA TALIBA Health Center

ANNEX IV - SUMMARY IMPLEMENTATION STATUS, BY COUNTRY

Annex IV. Table I: Implementation level in 7 selected districts, Zambia

Activity	Planned	Executed	% Executed	Notes
Boreholes	47	40	85	Costs increase, flooding
Radios	55	55	100	Installation underway
Mobile phones	29	33	114	
Vehicles	7	7	100	
Motorbikes	131	131	100	One health centre which received a motor bike does not have a trained and licensed motor bike driver.
Bicycles	638	636	99	Two bicycles lost in transit
Boats	2	1	50	1 not yet delivered
Stationary packs	3330	3330		
IGAs	6	4	66	Reduction in plans activities due to cost escalation
Community registers	7	7	100	

Annex IV. Table II: Summary implementation status by activity, Ethiopia.

GAVI HSS activities	Target set for the FY 2006 –08	Progress against the target
Activity 1: Upgrading skills of 25,050 HEWs	21625	22,833 trained
Activity 2: Apprenticeship for 12600 health extension students.	9175	10,600 benefited
Activity 3: Capacity strengthening for Woreda health management team	3720	7,841 benefited
Activity 4: Training of health workers for IMNCI	2700	1,473 trained till 2007 and in 2008, 703 health professionals an IMNCI case management, 20 on IMNCI facilitation skills and 31 on IMNCI supervision. Training was conducted at 23 sites.
Activity 5: Upgrading of 212 health stations to health centers	106	The construction of 212 GAVI-sponsored health centers is outsourced to GTZ, along with another 300 health centers funded by another sources. Of the total 512 HCs outsourced to GTZ, the construction of 180 has been completed in the year 2008. Of those completed, 70 are sponsored by GAVI HSS.
Activity 6: Equipment of 300 health centers	155	Procurement completed
Activity 7: Construction of 100 health posts	30	Funds secured initially for 100 health posts could only cover the construction of 30 health posts due to price escalation
Activity 7: Equipping of 7,340 health posts	7,050	The procurement and distribution of health post kits is handled by UNICEF. 3670 health posts are equipped.
Activity 8: Purchase and distribution of 109 Vehicles for 10 woredas		Completed
Activity 9: Purchasing and distribution of IT equipment for 109 woreda health offices		Procurement completed and reported last year.
Activity 10: Monitoring and evaluation		HMIS format was printed.
Activity 11: Support implementation of HCSS		The procurement and distribution is being done. The construction of central warehouse is on progress
Activity 12:Management of HSS		GAVI HSS workshop is conducted. Extensive regional monitoring visits were done by FMoH staffs

Annex IV. Table III: Summary implementation status by objectives and activities as of April/May 2009, Vietnam

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
Specific objective 1 To increase the number of Village Health Workers (VHWs) and improve the quality of the work				
Curriculum of 9-month training program for VHWs updated	Department of Research and Training	Completion of the curriculum by quarter 2/2008	Not completed (70%)	- One year delay in starting - Training before the completion of curriculum (old version was used)
Major training materials (plans and procedures for administration) for 9-month training program for VHWs updated	Department of Research and Training together with Provincial Secondary Medical schools	Completion of the materials by quarter 3/2008	Not completed	- One year delay in starting - A frame of curriculum was developed - Training before the completion of materials
Training materials printed and distributed to all project provinces	PMU	Copies of the curriculum and materials distributed by quarter 4/2008	Not available at project provinces	Old materials were used for training Different versions at different provinces
Facilitate the employment of VHWS to get 99 percent of villages under the project having a VHW	District Health Bureaus	Completed by 2010	On going	
Providing 9 month training course for VHWs	Province Health Office together with Provincial Secondary Medical schools	6,040 VHWs having undergone 9 month training by 2010	On going	
Providing basic equipment kit for VHWs	PMU	All VHWs having received basic equipment kit (with continuous refill) by quarter 2/2008	The procurement procedure completed All kits	One year delay in starting

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
			expected to be distributed in August 2009	
Monthly allowance for VHWs	Funds distributed through the salary system to provinces and further to districts that pay the salary	All VHWs receiving incentive of 50,000 VND per month every quarter during 2007-10	100% of VHWs receiving monthly incentive base on 3 levels of performance: A (very good)-50,000 VND; B (good)-45,000 VND and C (poor)-35,000 VND from Jan 2008	One year delay in starting Reduced incentive Positive points of performance classification
Monitoring manual/guideline for VHWs	PMU	Monitoring guideline developed for VHWs	The guideline was completed	
TOT courses for provincial trainers	PMU	1 TOT courses organized for provincial trainers	Has not been done	
Short courses for district officers	Provincial Health Offices	21 short courses organized for 751 district officers	Has not been done	
Support for monitoring and supervision	All levels	- At central level: 10 monitoring and supervision visits carried out in 10 project provinces - At provincial level: M&S visits carried out in all districts and communes - At district level: M&S visits carried out in all communes and villages	On going	90%
Specific objective 2. To improve the quality of Commune Health Workers (CHWs) and expand the reach of the commune health centers (CHCs).				
Training materials on EPI in Practice and on MCH printed and distributed to all	Provincial Health Office together with the National Immunization	Completion of the material by the quarter 2/ 2007	Not available	

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
project provinces	Program			
104 training course on reproductive, maternal and child health" for 4000 CHWs	Province Health Office together with Provincial Secondary Medical schools	Completed by 2010	On going 62 courses organised	Training without updated materials
104 training course on "EPI in Practice" for 4000 CHWs	Province Health Office together with Provincial Secondary Medical schools	Completed by 2010	On going 43 courses organised	Training without updated materials
Monitoring manual/guideline for CHCs	PMU	Monitoring manual/guideline for CHCs	Completed	
Provide a car to support monitoring and supervision	PMU	A car purchase and used	Purchased and used	
Recurrent cost for difficult CHCs	District Health Bureau	1,144 CHC received additional recurrent budget of 30USD per month during 2007-10	Started since Jan, 2008	The number of CHCs is more than proposed
Specific objective 3. To strengthen health system management capacity				
3.1. Health Planning and Magt Manuals	PMU	Health Planning and management Manuel developed for provincial and district health office	Completed (100%)	
3.2. Training for provincial and district officers	PMU			
3.2.1. TOT courses for provicial trainers	PMU	2 TOT courses organized for provincial trainers	Completed (100%)	
3.2.2. Courses for district officers	PMU	19 courses organized for 669 district officers	Not done	
3.3. HMIS support	PMU			
3.3.1. Pilot and update HMIS software	PMU	HMIS software updated and piloted	HMIS software updated	
3.3.2. TOT course on Software for district	PMU	A TOT course on HMIS	Not done	

Specific objectives and targets	Implementation responsibility	Plan	Current situation	Comments
staff		organized for district staff		
3.3.3. Computer courses for CHWs	PMU	15 courses organized for 419 CHWs	Not done	
3.3.4. Computers for prov, districts and pilot CHCs	Province Health Office	316 computers purchased and provided to PHDs, district health centers and piloted CHCs	7/10 provinces have purchased computers	
Objective 4. Policy development				
4.1. Innovative fund	PMU and Department of Planning and Financing	Some proposals developed and approved	On going (70%)	
4.2. Workshops, seminars	PMU and Department of Planning and Financing	Workshops organized in the central and provincial levels	On going (70%)	
4.3. To implement policy-oriented studies	PMU and Department of Planning and Financing	Some studies carried out	On going (80%)	
Support and Management	PMU			
Office equipment and furniture	PMU	Office equipment and furniture purchased and used	Have done completed	
Allowances for PMU	PMU	Director, Vice Director, Coordinator and Chief Accountant received allowances	All got allowance (100%)	
Contracted and admin staff	PMU	An additional program officer recruited	All staff recruited	
Running costs	PMU	Running costs (telephone, photocopy, stationery, ect) paid	All done	

Annex IV. Table IV: Summary implementation status by activity, Nepal

GAVI HSS activities to be completed by July 2010	GAVI HSS target set in AWPB for the FY 2008/09	Progress against the AWPB by the Q2-2008/09	Remarks
Activity 1.1: Upgrading skills of 2600 Village Health Workers (VHWs)	1200	1200	Target will be met by this fiscal year.
Activity 1.2: Upgrading 400 Auxiliary Health Workers (AHWs) to Senior AHWs	200	On-going	Will be completed as per AWPB
Activity 2.1: Expansion and inclusion of newborn care in Community Based Integrated Management of Childhood Illness (CB-IMCI) – 11 districts	11	11	Implementation is completed in all 11 districts.
	2	2	CB-NCP Reprogrammed for next FY
Activity 3.1: Develop and implement an urban MCH health plan in 5 major municipalities	Development of Urban Health Strategy	Final strategy developed	Roll of strategy and implementation of MCH health plans shifted to FY 2009/10.
Activity 3.2: Training of all Health Facility Management Committees (HFMCs) in 10 lowest performing districts (405 HFMCs)	Revision of curriculum	Completed	• Districts selected are: *Humla, Ramechhap, Kalikot, Solukhumbu, Manang, Bhojpur, Mustang, Mugu, Sarlahi, Rolpa* • District and facility level trainings ongoing
	10 districts trained at Central TOT	Completed	
Activity 3.3: Micro-planning for effective delivery of MCH and newborn health (including immunization) in 10 lowest performing districts	Devpmt of micro planning guideline	Completed	• Being implemented in 3 districts: Bhojpur, Manang and Rukum • 2 districts reprogrammed for next FY • 5 total b/ of per diem increase
	District selection	Completed	
	Micro-planning in 3 districts	In progress	
Activity 3.4: Establish health posts with birthing centers in 42 selected VDCs	Begin construction of 42 health posts	3 tenders awarded 39 to be awarded by end of year	In 3 of the districts tender had been called - anticipated to start work by May/June 2009.

Activity 4.1: Providing 100 pick-up trucks and 50 motorcycles	Pick- up trucks- 37	Reissued the bid	The first tender for 37 pick-up trucks was cancelled since none of the bidders were qualified and second tender has been called upon
	Motor-cycle- 100	Contract awarded	
Activity 4.2: Providing telephone lines to 50 DHOs; 11 district hosp; 101 PHCs	101	Completed	Implemented at the district level
Activity 4.3: Providing computers and related equipments, and email/internet facilities 50 DHOs & 71 District Hospitals	Target districts- 75 – 50 DHOs and 75 district hospitals	• E-mail/internet connected in districts • Contract awarded for computers	Computers planned to be distributed to the DHOs and district hospitals by end of this FY
Activity 4.4: Decentralizing the computerized Health Management Information System (HMIS) to 50 districts	Numbers of districts targeted- 50	• 20- computer personnel hired • HMIS web portal designed • 15 districts started electronic reporting	Other 35 districts will start electronic reporting from next FY after when they receive computers

Annex IV. Table V: Summary implementation status by activity, district level: four case study districts, Nepal

GAVI HSS activities to be completed by July 2009	Progress against the AWPB by the Q2-2008/09				Remarks
	Sindhuplachowk	Darchula	Sarlahi	Rupandehi	
Activity 1.1: Upgrading skills of 1200 Village Health Workers (VHWs)	20	13	25	Services targeted for the next FY 2009/10	
Activity 1.2: Upgrading 200 Auxiliary Health Workers (AHWs) to Senior AHWs	0	1	3		
Activity 2.1: Expansion and inclusion of newborn care in Community Based Integrated Management of Childhood Illness (CB-IMCI)	Completed	Completed	NA		
Activity 3.1: Develop and implement an urban MCH health plan in 5 major municipalities	NA	NA	NA		Strategy has been developed at the center

Activity 3.2: Training of Health Facility Management Committees (HFMCs)	NA	NA	Ongoing		Will be completed within this FY
Activity 3.3: Micro-planning for effective delivery of MCH and newborn health (including immunization)	NA	NA	NA		Reprogrammed for next FY
Activity 3.4: Establishing birthing centers	NA	NA	NA		The districts were selected after the case study work plan was developed
Activity 4.1: Providing pick-up trucks and motorcycles	-	-	-		Not yet distributed to the districts
Activity 4.2: Providing telephone lines	Completed	Completed	Not complet-ed		DHO not clear about the operational cost
Activity 4.3: Providing computers and related equipments, and email/internet facilities	Ongoing	Installed statistical software and district staffs oriented	Installed statistica l software		Email/internet facilities already exist and additional computers are being sent
Activity 4.4: Decentralizing the computerized Health Management Information System (HMIS)	Computer personnel hired	Ongoing	Ongoing		Computers are in the process of being sent from the LMD. Decentralized HMIS will operate after the provision of computers

NA- Not Applicable (This activity is not targeted to that particular district)

Annex IV. Table VI: Summary implementation status by activity, Kyrgyz Republic

Five components of HSS support	Activities and action points	Progress	Notes
1. Strengthening political commitment to immunization and ensuring financial sustainability	Conduct analytical work with relevance for strengthening immunization and primary health care and channel to policy process in the health sector, wider government, and parliament	In progress	One study has completed baseline data collection. Another study is finalizing its research questions and study design.
	Conduct advocacy activities targeting wider government, local governments, and the population	In progress	Mass media campaigns are conducted. RCHP developed guidelines and information material to train CSO's. European Immunization Week organized yearly.
	Provide accurate and timely information to MOH on financing requirements for ensuring full immunization coverage for preparation of annual budgets and the MTBF	Not done	Government unable to meet obligation of the country to share resources used for procuring adequate amounts of vaccines. Fund allocation decisions are made in spring, which does not allow RIC to procure vaccines in a timely and efficient manner.
2. Improving physical infrastructure and working conditions of primary care and public health services	Purchase 27 cars for surveillance and mobile team	Done	18 (target reduction due to cost escalation)
	Purchase 10 refrigerating equipment	Done	30 regular refrig. purchased [17]
	Renovate 16 rayon-level vaccine warehouses	Done	35 warehouses renovated but not in the manner originally planned.
3. Improving access to high quality primary care through capacity building, improved management and introduction of economic incentives	Conduct training for 26 feldsher-midwives in "Immunization in Practice" (WHO curriculum)	In progress	15
	Develop mechanism for "supportive supervision" of primary care staff for performance improvement including immunization coverage: develop manual, train supervisors, conduct joint supervision trips with MHIF in each of 40 rayons.	In progress	Methods/guidelines developed and approved by MoH and being piloted Training activities will start in during 2009.
	Organize mobile teams in each of 40 rayons that will visit population points without medical services 4	In progress	Not progressing/the MoH is estimating requirements and organizational arrangements

[17] According to the application it was proposed to purchase 10 specialized vaccine refrigerators. However, 30 ordinary refrigerators were procured for vaccine-storage in health facilities. The 30 refrigerators were distributed among Oblast Immunization Centers, FGPs and FAPs. Distribution was mainly driven by availability of refrigerators in and localization of the recipient health facilities, i.e. remotely located facilities received priority.

Five components of HSS support	Activities and action points	Progress	Notes
	times year		
	Train primary health care staff on integrated surveillance of infectious diseases and provide support for its implementation	In progress	Preparations under way, but the training has not yet started
	Develop mechanism and indicators for performance based pay for primary care providers, implement it in a phased approach and conduct evaluation of its effectiveness to improve quality and staff retention after Year 1 & Year 2. Contribute government funds to increase the number of recipient providers after Year 1 and move to full self-financing after 2010.	In progress	Indicators selected and base line values collected. Guidelines developed and incentive system piloted
4. Strengthening routine monitoring of immunization activities and coverage at the level of primary care and public health;	Develop and introduce vaccine status register and immunization calendar	In progress	In finalization stage
	Create electronic reporting for immunization activities in primary care by revising the primary care reporting form of the Medical Information System	Not done	Maintenance of Health Information Systems institutionalized, with IT staff capable to work on a wide range of tasks, including information systems developed for improved immunization management.
	Monitor the timeliness of immunization activities in line with immunization calendar	Not done	Challenge: TA required improve immunization data quality produced by PHC providers through routine processes.
5. Social mobilization and active involvement of the population in health promotion and prevention	Develop regular contact with NGO's working among urban migrants in Bishkek and Osh cities where under-coverage is significant	Not done	Technical guidelines and materials to train CSOs prepared.
	Conduct capacity building for providers to work with civil society organizations to help conduct outreach and communication activities in order to generate demand for timely primary care and immunization	In progress	A Small Grants Program created, a Review Committee established. 1st round announced in media.

ANNEX V - TARGET AUDIENCE FOR RECOMMENDATIONS

	Target Audience for Recommendations	
	Country policy and program decision-makers	Stakeholders in-country
DR Congo	Have CNP and DEP provide more information to stakeholders through regular briefings or other mechanisms • The Country Case Study workshop showed that many stakeholders are not informed of the developments of the HSS activities and plans in DRC. Discussions with stakeholders (notably NGOs and other divisions at the MoH) can provide input on how to implement activities. This could be achieved through more frequent (possibly quarterly) meetings with stakeholders on HSS implementation. • The calendar of activities needs to be revised to reflect the substantial implementation delay. Apply the CSO grant experience and immunization provincial ICCC model • The CSO grant is an example on how funding can flow to health zones (HZs). DRC has a long tradition of using NGOs to support and provide health services to HZs. Lessons can be learned from this experience, both in terms of financing models for HZs and implementation. • The Inter-Agency Provincial Committees were created for the immunization program. These committees are not functional in all provinces and may need additional support from the HSS GAVI funds. Create links between new MOH/PMU and the Fiduciary Agent • A PMU will soon be operational within the MOH. Roles and responsibilities between the PMU and the GAVI HSS fiduciary agent need to be established and transparent, as the two will function separately. Put into place the audit systems, as described in the proposal • The GAVI HSS proposal includes a number of audits (internal and external) to be conducted during implementation and before the end of the grant. To date, these have not been put in place. As the burn rate increases, it is important for these audits to be in place to avoid possible implementation issues at a later stage. Provide the necessary support to provinces, as outlined in the proposal • Support to the provinces has not yet begun. Provinces are to support the HZDPs and budgets prepared by the HZs, but the current plans received by the DEP were not reviewed by the provinces. - The roles of governors, provincial ministers of health, and provincial medical officers should be clarified as part of the CPP mandate. - The CNP, in its role of inter-agency coordinator, needs to inform and provide assistance to intermediate levels. This will help to increase their understanding and participation in the HSS process. Use the two tools developed by the School of Public Health • The HSS indicator tool can be used with the existing HMIS to ensure complementary tracking of HSS implementation and impact. • The operational research tool will be useful to measure the impact of the salary supplements provided through the GAVI HSS grant. Operations research is	

	Target Audience for Recommendations	
	Country policy and program decision-makers	Stakeholders in-country
	budgeted in the HSS grant. Therefore, the CNP and the DEP should use these funds to incorporate this study protocol and fund its implementation. Harmonize the salary supplements strategy • There are various salary supplement systems being implemented in DRC, based more on donors' experiences than a national consensus of what works and what has impact. As 25% of the GAVI HSS proposal goes to salary supplements, the CNP would benefit from having a defined vision of how it plans to provide and track these funds to the HZs. • Operationalize the Human Resources component of the GAVI HSS grant • Strengthen links with institutions working on human resources issues (e.g., Department of Secondary Education, universities and other training entities).	
Ethiopia	• Sustain the participatory process and ensure the involvement of stakeholders not included previously at national and regional levels. • Make further efforts to strengthen the coordination and management capacity of the health system at regional and lower levels. • Step up efforts to strengthen supportive supervision that is guided by standard operation procedures at all levels. • Sustain the competence and motivation of trained health workers by providing continuous refresher training and reference materials. Strengthen the capacity of the regions to manage in-service training programs. • Strengthen efforts to encourage greater involvement of the civil society and private sectors in the health sector development initiatives. •	• Multi- and bilateral development partners should contribute to the strengthening of the HMIS. • Multi- and bilateral development partners should come forward to negotiate common grounds with the FMOH to contribute their share to the country's health sector development plan without causing system fragmentation. • NGOs, CSOs and the private sectors must be proactive in the health sector development process through the agencies representing them on coordinating committees (CJSC and JCCC). • Adherence to the pooling of funds and use of the government systems and procedures should be encouraged. • To ensure transparency and accountability, awareness should be created about the GAVI HSS activities across the sub-national level.
Kyrgyz Rep.	• Improve the mechanisms of the development of proposals for incentive building for community involvement in the immunization process (Component 4). • Improve the information system to achieve better registration of children who have had vaccinations in order to solve the problem of migration of mothers and children either in- or	• Strengthen the analytical work on the immunization program. • Train national supervisors with the methods of evaluation of vaccination coverage. • Strengthen the coordination between development partners (UNICEF, WHO, the World Bank) in particular in regard to the maintenance of refrigerators.

	Target Audience for Recommendations	
	Country policy and program decision-makers	Stakeholders in-country
	outside the country.	
Nepal	MoHP • MoHP should continue to use and further refine the participatory process and involvement of various stakeholders in needs assessment and prioritization processes in the GAVI application process. • Demand-side barriers should be identified during needs assessments and activities should be included in future proposals, which will lead to social inclusion and equity. • Representatives of Umbrella NGO Organizations such as the Association of International NGOs (AIN) should also be involved at the central level during needs assessments and prioritization processes. • Process indicators which are measurable and meaningful to ascertain progress should be included as complementary to HMIS. • A mid-term review of the GAVI HSS proposal should be done to make necessary amendments to the targets and implementation schedule. DoHS • DoHS should take measures to reduce delays in authorization and monitor budget release, expenditure and reporting. • Pooling and training of health workers who have not received training in CB-IMCI should be planned and implemented through future GAVI HSS or other sources. • Planning for short refresher training in CB- IMCI for those who have completed five years after training to update them and improve the quality of training should be started. • The procurement process for vehicle procurement should be expedited. • A plan for scaling up Urban MCH should	

	Target Audience for Recommendations	
	Country policy and program decision-makers	Stakeholders in-country
	be developed, taking lessons learned from the current Pilot and included in the upcoming NHSP-2. • A budget and supervision and monitoring plan should be provided to ensure quality and timely completion of Health Posts with Birthing Centers. • Regular back-up support facilities for IT should be provided at the district level.	
Vietnam	• The component on policy and innovative solutions in the GAVI HSS in Vietnam needs to be given higher priority and should be further strengthened. It can be concluded that operational activities are easier to implement than policy-oriented activities. It is recommended that this be given due consideration in the future so that relevant policy issues are addressed early on and due attention is given to the need to strengthen policy development capacity. • There is a growing willingness in Vietnam to include other stakeholders in public health planning and coordination. This should be strengthened with more regular meetings, with the GAVI HSS regularly included on the agenda for HPG and ICC. At the provincial level, province health bureaus should be further encouraged to coordinate with all partners in the province. • There does not seem to be any collaboration between the Department of Planning and Financing and EPI, and EPI does not seem to be involved in any aspect of the HSS. This should be corrected. • The HSS project has successfully provided CHCs in the project provinces with an additional	• Since the dominating modality for donor assistance in the health sector is the project modality, donors should increasingly comply with the Hanoi declaration and move away from the project modality. Donors should harmonize requirements for project planning and formats for project proposals and requirements for financial accounting and reporting requirements. • Civil society organizations should continue to push for better coordination with all development partners in the health system.

	Target Audience for Recommendations	
	Country policy and program decision-makers	Stakeholders in-country
	recurrent cost of US $30 per month. These funds partly supported CHCs in the worst-off provinces, especially in disadvantaged communes to cover basic operations. Thanks to that support, those CHCs had full electricity for freezers to keep vaccine and drugs in a good condition. This support should continue after the project period and be extended to the whole country. • Provincial data is not provided in the reports to GAVI, although the HSS is directed only to 10 out of 64 provinces. National level indicators are unlikely to show any changes attributable to the HSS, and it is recommended that implementation be monitored through the use of provincial-level data.	
Zambia	• Clear up the first-year backlog. • More effectively plan to facilitate logistics and tender procedures. • Target support to low-performing districts. • Enhance the technical role of the planning and policy development directorate of the MoH in GAVI HSS. • Explore the possibility of developing an implementation manual for districts receiving GAVI HSS support. • Appoint a GAVI HSS focal point to oversee implementation. • Strengthen the MoH and PHO link. • Improve IGA performance and sustainability.	• Ensure joint monitoring with other relevant programs. • Improve private provider, NGO and CSO participation in all GAVI HSS activities.
	•	•

ANNEX VI - TECHNICAL ASSISTANCE INCLUDED IN THE HSS PROPOSAL AND STATUS

COUNTRY[1]	TECHNICAL ASSISTANCE NEEDS IDENTIFIED IN HSS APPLICATION	POTENTIAL SOURCES	TECHNICAL ASSISTANCE ACCESSED (SOURCE, TYPE)
ETHIOPIA	*Support for health commodities system roll-out*	*Not identified*	*No TA accessed*
DR CONGO	*Training of provincial teams in target provinces in planning, M&E*	*DEP and partners (e.g. Belgian Cooperation, UNICEF)*	*No TA accessed*
	External monitoring of implementation 2-3 times annually	*independent consultants, local or Western universities, or partners with expertise*	*No TA accessed*
	External assessment at mid-point and completion	*Not identified*	*No TA accessed*
ZAMBIA	*Design related to the income generating activities for neighborhood health committees*	*Local consultants*	*No TA accessed*
	Mid-term review of HSS implementation	*Intl' assistance*	*No TA accessed*
NEPAL	*Introduction of CB-IMCI in 11 districts (using same outsourcing model as other districts)*	*Nepali Technical Assistance Group (NGO); Nepal Pediatric Association, and United Mission to Nepal (NGO)*	*Contracted*
	Skills upgrading of auxiliary and village health workers	*Local training institutions*	*Contracted*
	Installation of phone lines	*Local firms*	*Contracted*
	Mid-term review of HSS progress	*Partner agencies*	*No TA accessed*