



GAVI Health System Strengthening Support Evaluation

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Georgia Desk Study

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Acronyms and Abbreviations

APR	Annual Progress Report (GAVI Secretariat)
EPI	Expanded Programme of Immunisation
HSS	Health System Strengthening
MCH	Maternal and Child Health
MOLHSA	Ministry of Labour, Health and Social Affairs
PRSP	Poverty Reduction Strategy Paper
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
WHO-EURO	WHO Regional Office for Europe

Summary of key findings, conclusions and recommendations

The GAVI HSS programme in Georgia aims to contribute to increased and sustained immunization coverage through the provision of support to ongoing health reforms at the national and rayon (district) levels. The main focus of intervention is on rayon and primary health care provider levels.

Ranking 96 on the UNDP Human Development Index, Georgia has about 4.4 million people, of which 52% live in urban areas. Due to a significant decline in socioeconomic conditions in the 1990s, the health status of the population deteriorated seriously, particularly life expectancy for men. No health indicators are favourable in comparison with western countries.¹

The GAVI HSS programme is planned over a period of 4 years (2007 – 2010) with a total budget of \$1,020,906, joint-funded by the Government of Georgia and GAVI HSS funds. The total fund provided by GAVI - in line with the \$2.5/ newborn guidance - is \$434,622; a modest amount compared with many other GAVI HSS countries receiving multi-million USD funds. This \$1m programme aims to have an impact on the public health services at the local level aiming to benefit at least two thirds of the total population. Since the programme is targeting both operational (rayon) and systemic (national) levels it is reasonable to infer that a general impact on the health system as a whole should be felt.

The key findings arising from the desk review of Georgia's GAVI HSS support in relation to our key evaluation questions (*listed on page 10*) include the following:

- The fact that a **detailed assessment / analysis around options for HSS support** against specific criteria was conducted during the design of the programme should help to contribute to a higher degree of programme success – this could be worth further exploration in later evaluations
- **The programme is well aligned with the ongoing health care reform agenda** in Georgia which aims to increase the utilization of quality primary health care services.
- **The commitment of the MoLHSA** to joint-fund the GAVI HSS programme implies that the government support to HSS at a strategic level

¹ WHO country profile August 2008 http://www.who.int/hac/crises/geo/georgia_profile_aug2008.pdf

- **However, the apparent lack of separate HSCC / body dedicated to championing HSS issues** could be a) holding back the health systems strengthening agenda / ownership of HSS issues within the MoLHSA level and also b) missing an opportunity to promote coordination of HSS efforts within all stakeholders within the health sector
- **The flexibility of GAVI funds that allows support to a strategic and changing agenda was cited as a positive factor** – i.e. in the context of Georgia's health care reform, uncertainly around its resolution/ conclusion and where this may impose delays for GAVI HSS activities. **In future assessments** it will be interesting to investigate what GAVI HSS has been able to contribute in the context of Health Care Reform II and to also look at **how the GAVI HSS programme has evolved to fit in with the changing environment.**
- It has not been possible to understand from this review the full extent of issues in relation to relatively slow rate of activity taking place in Georgia. However, in the context of major health care reform being an obvious priority for the MoLHSA **it would appear that GAVI HSS is currently 'off-track'.**
- **The quality of HSS APRs** is questionable and clarity around how decisions to continue disbursing funds is not at all clear
- As a percentage of the Government led HSS Program funding, GAVI is providing approx. 43% in Georgia; a significant input with regard to this specific program. However, this is a modest amount compared with other agency support for Health Care Reform in Georgia; from major players such as the EU², WB, USAID (and DFID until 2008).
- It will be difficult to attribute success in outcome/ impact indicators to GAVI HSS efforts as insufficient logical links have been made between GAVI HSS outputs and the higher outcome/impact level. **It should, however, be possible to track key progress against outputs at rayon and facility levels** and thereby track the extent of achievement at output level of GAVI HSS efforts through progress reports. **It is not clear in the existing results framework that outcome or any qualitative observations will be captured through existing results framework** (e.g. in respect to improvements in quality and efficiency of interventions through the introduction of supportive supervision and improvement of management skills of public health specialists at the district level)
- Due to the nature of its design and close alignment with the Health Care Reform Agenda II **GAVI HSS support promises to contribute to sustainability efforts.**

² E.g. Providing 5 million Euro between 2008-2010 supporting primary health care reform

- Finally, since its interventions are targeting population coverage at district and facility levels **it is reasonable to expect that immunization coverage for some of the hardest to reach populations may be improved**

Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Georgia in June – July 2009 as part of the GAVI HSS Evaluation Study. The evaluation conducted 11 In-depth case studies in the following GAVI HSS recipient countries, Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. This current study is one of an additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

1.2 Brief conceptual framework of the Evaluation

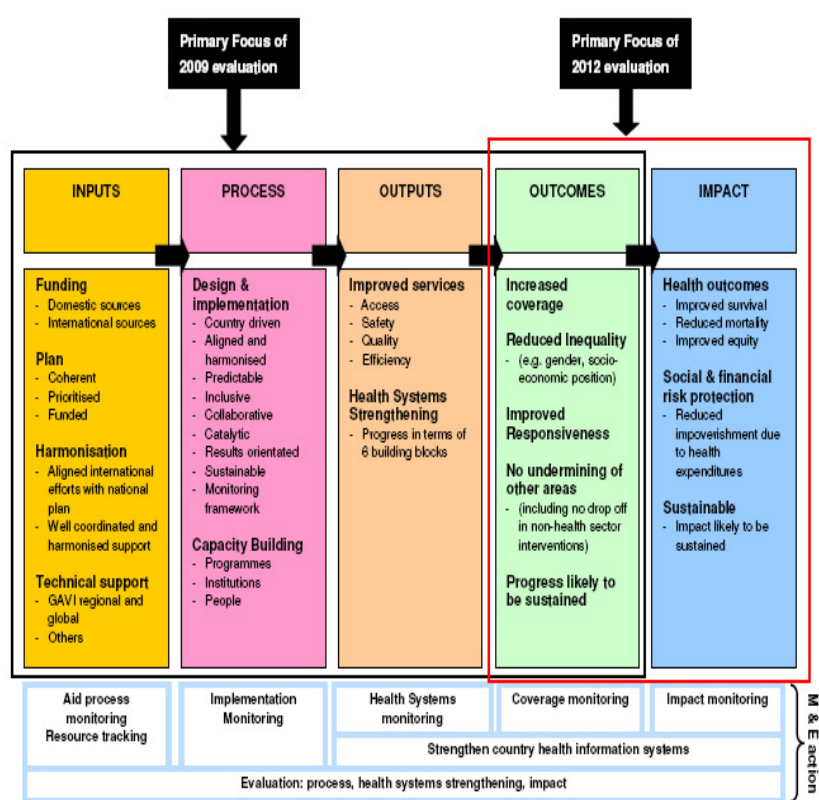
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note, given the little time elapsed since the first HSS applications were approved in 2006, that this evaluation – the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant

implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the “right” bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Georgia Deeper Desk Study

The Georgia Deeper Desk Study used a combination of document review, email and telephone interviews in order to gain insight into how GAVI HSS funding has support health system strengthening more generally in the country. Both the document review and interviews took place in late June / early July 2009. Appendix 1 provides a list of resources for the Georgia desk study. Despite having contacted a number of other stakeholders in Georgia, three people were interviewed and only one of these was directly implicated in GAVI HSS. The remaining two were able to provide useful contextual information. Unfortunately it was not possible to reach the person within the Ministry of Labor, Health and Social Affairs (MoLHSA) who originally led the HSS proposal as this person has since moved on.

2 The GAVI HSS proposal – inputs, outputs and progress to date

2.1 HSS proposal design

The design process for the HSS proposal apparently followed the same process observed for all GAVI funds in Georgia:

1. Attendance of country representative (EPI manager) at WHO EURO regional workshop
2. The representative then discussed the opportunity with the MoLHSA
3. Once the MoLHSA agree to pursue this further WHO organised consultancy inputs to provide technical support to the decision making and the application development process
4. The ICC endorses the decision to put forward an application and commits to support and review this process

The GAVI HSS program in Georgia aims to contribute to increased and sustained immunization coverage through the provision of support to ongoing health reforms at the national and rayon levels. The main focus of intervention is on rayon and primary health care provider levels. Assessments that were previously carried out by development partners around the formulation of HSS options in Georgia identified two major bottlenecks to improving the health system: Human resources and physical infrastructure.

The Government of Georgia (GoG), the World Bank (through its support to Georgia Health Reform II), EU, USAID and DFID were already supporting the rehabilitation of PHC facilities and hospitals. In 2006 the MoLHSA took the decision to apply for GAVI HSS funds to address the human resource issues. The MoLHSA chose to focus specifically on a) improving professional skills and b) introducing new standards and methodologies.

The national task force leading the proposal development process took the HR related recommendations from previous assessments / studies of the health sector as a starting point and carefully considered the relative strengths of the different intervention options against a number of key criteria. Among these sustainability, impact on immunization, impact on health system capacity, affordability, relevance to GAVI themes, and others were included. This systematic approach to analyzing the various benefits of the different options of intervention was

applauded in the *GAVI good examples paper* as a particularly good example of country alignment³.

The following five objectives were finally adopted:

1. Motivation of medical personnel necessary to ensure planned (desired) immunization coverage rates is institutionalized

GAVI HSS contribution (\$12,000) to this objective was subsequently dropped in Year 1 (reported in 2007 APR) due to a change in the way the Government funded the National Immunization Plan: In 2008 the GoG began paying all medical staff/ facilities salaries according to the number of vaccinations made in order to improve vaccination performance, as opposed to paying bonuses once a year to primary health care service teams for high rates of immunization coverage (as had been previously planned). The \$12,000 of GAVI HSS funds that had been allocated to conducting an assessment in 2008 of this earlier GoG motivation mechanism (based on its implementation in 2007) was considered to be no longer a useful exercise as the assessment findings were to inform future policy decisions for developing effective immunization motivation mechanisms; expected to have been included in following year's State Health Program.

2. Increased professional skills of public health specialists at the rayon level
3. Supportive supervision introduced at the rayon and health facility levels
4. Increased skills of PHC medical personnel (doctors and nurses) related to immunization
5. Improved capacity of Public Health institutions to deliver services (e.g. through purchase of truck to deliver vaccines)

2.2. HSS application and approval processes

The application development was led by a national task force comprised of 5 nationals and 1 international consultant identified by WHO as well as representatives from the Ministry of Labour, Health and Social Affairs. GAVI HSS proposal development funds were used to pay for these consultancy and the funds were channeled via UNICEF.

During ICC meetings the ideas and proposed intervention focus was presented by the consultancy team for discussion and agreement. Originally the intention was to establish a separate HSCC to coordinate GAVI and all other HSS interventions. However, since the same members were implicated in both HSS and all other GAVI funds in Georgia (ISS, NVS-Hep B,

³ GAVI support for health system strengthening; Good examples from country proposals, GAVI Alliance Secretariat

INS) a separate committee was never established. The ICC⁴ simply assumed a broader remit to include HSS discussions in addition. Proposed objectives and intervention areas for GAVI HSS were discussed and agreed upon during ICC meetings therefore. As in many other countries the draft proposal was circulated among all committee members and presented before the committee for discussion / approval prior to submission indicative of an intentionally inclusive process.

In terms of the external review and approval process in Georgia, the IRC approved GAVI's HSS proposal 'with clarifications' within two months of its submission. Approval with clarifications essentially means that the proposal was formally approved but further minor clarifications were needed. These clarifications included: 1) Expanding upon Objective 1 'motivation of medical personnel' to explain what this intended to include aside from training and providing a justification around how a single assessment of motivation mechanisms planned for 2008 (only a year after GAVI HSS support) would enable impact on immunization effectiveness and efficiency to be captured; 2) Questioning the extent to which the Health Sector Coordination Committee (HSCC) was functional; 3) Clarification around how GAVI HSS progress would be monitored both technically and financially, and finally; 4) Providing justification around why a separate project manager was needed for GAVI HSS when the proposal also stated that the interventions would be integrated into mainstream programs, and finally; 5) Rectifying some budgetary discrepancies. There is evidence of Georgia responding to each of the IRCs clarifications (submitted to GAVI end of May 07) and final formal GAVI Board approval was received via letter dated 13 June 07 stating that the IRC found these clarifications to be satisfactory. The first tranche of funding was received two months later in August. Written feedback from WHO and DFID in response to the IRC's request for clarification were annexed to the Georgia's proposal clarifications submitted.

⁴ The ICC comprises the Deputy Minister in charge of MOLHSA, the NCDC & PH, Head of PHD, Head of Sectoral Policy Dept MoLHSA, Adviser to Sectoral Policy Dept, MoLHSA, Head of Health Dept, Head of Finance and Budget Dept, UNICEF, VRF, WHO, Curatio International Foundation, NCDC, SUSIF, WB, DFID, EU, USAID / Caucasus Humanitarian Response Office.

Table 1: Key milestones in the application development and approval process

Key milestone	Who involved	Date
Decision made to submit an HSS proposal	During ICC mtg. Head of Sectoral Policy and Planning Dept., MoLHSA, chaired meeting.	Sept 06
Proposal submitted:	Following endorsement from HSCC	2 March 2007
Approval with clarifications from GAVI board obtained	IRC recommendation for approval with clarifications	25 April 2007
Submission of clarifications	Sectoral Policy and Planning Dept., MoLHSA	31 May 07
Formal final GAVI Board approval	GAVI Board on recommendation of IRC following IRC review of clarifications	13 June 2007
Funds received		Aug 07 (instead of May 07)
Official start date	Special Decree of Director General of the National CDC	Sept 07

2.3 HSS start up measures

Following approval in April 2007, the 2007 APR reported that there was a delay in the start-up of activities due to a three-month delay in receiving GAVI funds. The first tranche of \$69,000 was received in country in August 2007, as opposed to May when they had been expecting funds. The reason for the delayed disbursement is not clear. Of the first tranche of funds for Year 1 activities, \$35,700 was spent in 2007 giving a spend rate in the first year of 52%; good considering the reduced length of the year due to the disbursement delay. These funds were used primarily to procure the truck for transportation of vaccines (objective 5).

2.4 Annual Progress Reporting (APR) on HSS

Two APRs (2007 and 2008) have been completed by Georgia to date, however, very limited information was included in relation to the HSS programme. The extent of progress in country and information around challenges affecting the implementation of GAVI HSS are not clear at all from the two APRs available.

In terms of support received from technical partners to the APR process, WHO Country Officers apparently review and also translate the APRs into English. WHO EURO (Regional Office) and ICC members are also required to review and comment on the APR before submission to GAVI.

The 2008 IRC report on the country's 2007 APR provided very limited data other than financial information and no qualitative data around implementation issues. The IRC have, however, approved disbursement of the next tranche of funds as requested by the country for 2009. This seems a little odd as there is no explanation as to what this decision was based on (given low levels of activity and substantial funds already remaining from Years 1 and 2), especially when 'delays in utilization of funds' is cited in the *Revised GAVI HSS Guidelines* for the 2009 as one potential reason for the IRC recommending that subsequent annual funding *not* be disbursed.

2.5 HSS progress to date

Progress to date appears to be modest despite having received funds for the first three years of activities. From the APR reports the following information is available:

During 2007 Objective 1: *Increase the motivation of medical personnel* - was removed from the project. This was due to changes in the funding mechanism of the National Implementation Plan by the Government as a result of the ongoing Health Sector Reform II. Therefore \$12,000 of funds allocated for the motivation assessment were removed from the project. In sum in 2007, from the \$69,000 received in August 2007 a total of \$35,700 was spent on two things:

1. Objective 2: *To increase professional skills of public health professionals*:

Spend: **Preparation of guidelines by national/local consultants began**

2. Objective 5: *Streamline the supply of vaccines and injection materials and ensuring smooth operation of cold chain*:

Completed: **The truck was procured for the transportation of vaccines, equipment and injection supply from national to district levels.**

In 2008 a further \$119,500 was received and \$32,163 spent giving a lower rate of expenditure in the second year of 27% (compared to 53% in Y1). The following activities were completed:

Objective 2: *To increase professional skills of public health professionals:* Completed:

The MoLHSA organised and conducted a vaccines campaign against measles and German measles. All the other projects were postponed until 2009.

Objective 4: *Increase knowledge and skills of medical personnel:* Completed: **Due to the introduction of a new vaccine (HIB) in 2009, seven central and 116 regional training sessions for 2460 doctors and midwives were conducted.**

Regarding the above progress against objectives, no explanation was included and it is therefore difficult to know whether or not these activities were *additional* to regular GoG vaccination efforts.

It is also noted that Objective 3: Supportive supervision, will take place between May and December 2009.

It has not been possible to understand from this review what the issues are in relation to relatively slow rate of activity taking place in Georgia, however, with the information available it would appear that GAVI HSS is currently 'off-track'. Stakeholders interviewed were not au fait with the details around implementation of specific activities but suggested that the ongoing health care reform agenda may be distracting MoLHSA attention to more pressing / high-level issues.

2.6 End of HSS Assessment

To date the level of activity completed in Georgia has been fairly limited, therefore it will be interesting to look in more detail at the remaining two years activity (2009-2010). Especially in the context of Health Care Reform II it will be interesting to investigate what GAVI HSS has been able to contribute to this / how the GAVI HSS programme has evolved to fit in with the changing environment. The feeling in WHO was that the type of support provided by GAVI HSS should lend itself well to adaptation within this context, as it is supporting human resource improvements; needed irrespective of the type of health system architecture. This is a good example of GAVI HSS funds being open to being applied flexibly.

2.7 Support systems for GAVI HSS

The program is being implemented by the National Centre for Disease Control and Public Health. Overall responsibility for the program management sits with the Sectoral Policy Planning

Division of the Ministry of Labor, Health and Social Affairs. The Sectoral Policy Planning Division is in turn accountable to the ICC. Via their membership in the ICC and participation in ICC meetings, development partners contribute to overseeing and monitoring GAVI HSS.

In terms of financial management: GAVI HSS funds are received into the NCDC account (as are all other GAVI funds) and subsequently managed and disbursed through national systems and in line with procedures. Reporting takes place at the national level as well as providing progress reports on GAVI HSS funds specifically, submitted to the ICC for review prior to submission to GAVI. The Head of Finance and Budget Dept. of the MoLHSA is also a member of the ICC, which should help to increase the accountability of GAVI HSS funds within the overall health sector expenditures.

2.7.1 Technical support for proposal design and approval

WHO appeared to play a fairly significant role in the proposal design and approval process. WHO EURO organized regional (supra-national) workshops and WHO CO organized the consultancy team to write the proposal. All ICC members were given the opportunity to review the application and were required to formally endorse it (via signature) prior to submission to GAVI.

2.7.2 Technical support to the APR

As per the application development process, all ICC members are also implicated in reviewing GAVI Annual Progress Reports including HSS inputs. In addition to its reviewer role, WHO CO also translates the APR as required into English. Apparently there has been some confusion between GAVI HQ and the MoLHSA who believed it acceptable to complete the APR in Russian only (since they had been given APR templates in both Russian and English), however, on submission of the Russian version they were told that they must also submit an English translation. WHO is supporting the translation process.

2.7.3 Technical support for HSS implementation

As mentioned earlier the NCDC & PH are implementing GAVI HSS. Unfortunately it has not been possible to speak with anyone from the NCDC & PH. In the same way that the ICC were

implicated in the application development process they play a monitoring role in the implementation of HSS through reviewing and endorsing (with signatures) all progress reports prior to submission to the GAVI Secretariat. The HSS proposal outlines very clearly how the various development partners are expected to provide technical coordination support to GAVI HSS, however it has not been possible in this desk review to assess the full extent to which this is happening among all stakeholders.

3 Alignment with GAVI HSS principles

This section will attempt to analyse the extent to which the Georgia HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equity issues – does GAVI HSS attempt to support an equitable distribution of health?

3.1 Country Driven

As mentioned in section 2.1, WHO first informed the MoLHSA of the GAVI HSS opportunity. The MoLHSA subsequently agreed to pursue HSS funds during the ICC meeting of September 2006, chaired by the Head of the Sectoral Policy and Planning Dept. The decision was made to use GAVI HSS funds in a strategic way to support the Health Sector Reform agenda largely at district and facility levels. The focus of intervention efforts are at district and below levels, however the impact of the programme promises to be felt at both operational and upstream levels – aiming to result in better immunization coverage as well as a stronger national health workforce. It is difficult to say more about how the thought process of the MoLHSA at the time of applying for HSS funds as it has not been possible to speak to anyone within the MoLHSA. It is also worth noting that the MoLHSA are jointly funding the HSS programme, providing approx 60% funding to GAVI's 40% which would suggest a high level of commitment to strengthening HS within the government.

3.2. Is GAVI HSS aligned?

Alignment with broader development and health policies

GAVI HSS is aligned with key strategies and policies in Georgia with implications for the health sector including Georgia's Economic Development and Poverty Reduction Program (EDPRP) launched in 2003; Georgia's Health Policy (1999-2010); the comprehensive Multi-Year Plan for Immunization (2007-2010) and Health Sector Strategic Plan. As seen in section 2.1, it is also feeding into the Health Care Reform agenda with also aims to tackle human resource issues.

Alignment with budget and reporting cycles

Georgia's fiscal year runs from January to December. The project annual implementation plan with the budget is approved by the MoLHSA to ensure consistency with the MTEF/budget cycle. GAVI HSS funds are being channelled to the bank account of the NCDC (as per all GAVI funds) and managed, disbursed and reported in accordance with the national legislation. It is not clear how the GAVI HSS activity reporting fits in with national health sector reporting requirements.

3.3. Is GAVI HSS Harmonised?

There is no SWAp in Georgia, however, GAVI HSS funds appear to be harmonised as far as possible within the existing structures. For example, all GAVI funds are channelled to the NCDC & PH account to ensure that all GAVI funds are accounted for in one central place.

Key development partners who have a history of involvement in health sector reform in Georgia are all members of the ICC (e.g. DFID, USAID, EU, WB, UNICEF) as well as those active in immunization support services (VRF, UNICEF), however it is not clear from ICC minutes and interviews that higher level HSS issues are discussed at this forum as was the original intention according to the HSS proposal. Minutes do refer to GAVI HSS issues on occasion but no other / higher-level HSS discussions appear to be taking place during ICC meetings. The HS focal point in USAID, for example, who is a key stakeholder and involved in health system strengthening efforts (health financing efforts as part of the health care reform) did not know anything at all about GAVI HSS. The decision not to set up a separate coordinating committee for HSS appears to have been made to avoid burdening the same stakeholders with additional meetings/ reporting etc, however, there is an important risk in doing so that broader HSS issues will not be sufficiently championed / pursued by the MoLHSA.

3.4. Is GAVI HSS funding predictable?

Aside from the initial delay of 3 months, it appears that funds have been received on time in Georgia. The fact that only 36% of the total funding received has been spent suggests that predictability is not an issue for Georgia.

An important 'added value' of GAVI HSS was believed to be the fact that it allowed the country to plan longer-term than other types of donor / agency support.

3.5. Is GAVI HSS accountable, inclusive and collaborative?

GAVI HSS does appear to be accountable, and it appears to be inclusive and collaborative to a certain degree and to the extent of the ICC. The main body in charge of reviewing and approving GAVI HSS is the ICC; an inclusive existing body with representation from key stakeholders in health in Georgia. The National Centre for Disease Control and Public Health (implementing agent for GAVI HSS) is accountable to the Health Sector Coordination Committee via quarterly and annual reporting (financial and activity/progress reports) which are endorsed by the ICC before submission to the GAVI.

As mentioned earlier in 2.7 GAVI HSS funds are being channelled to the bank account of the NCDC (in line with national legislation) and managed, disbursed and reported in accordance with the national systems and procedures and are therefore accountable under existing government systems and reporting lines.

In terms of inclusiveness and in particular of civil society, there have been no specific links with civil society during either proposal design or during implementation of GAVI HSS. Although stakeholders interviewed pointed out that the MoLHSA have apparently tried hard to encourage civil society participation and engagement, as civil society in Georgia focuses predominantly on HIV/AIDS efforts, there are very limited/ no NGOs engaged in immunisation or health systems strengthening efforts.

3.6. Does GAVI HSS have a catalytic effect?

It is difficult to say whether or not GAVI HSS has a catalytic effect in Georgia. Although GAVI HSS could have provided the impetus for the establishment of an HSCC to promote government ownership of HSS issues it appears that this did not happen. The long-term mandate of the HSCC envisaged was to continue coordinating measures aimed at strengthening the health care system financed by various different sources (e.g. state budget, GAVI HSS, GFATM etc).

3.7. Is GAVI HSS Results Oriented?

The GAVI HSS proposal uses a results framework to report on progress using many process and output indicators as well as the three core GAVI HSS indicators (U5M, DPT3 coverage at national level and DPT3 coverage at district levels). However, there is no clear linkage made between outcomes and impact.

The goal of the program is to contribute to the increase and sustained immunization coverage through the provision of support to ongoing health reforms at the *national* as well as rayon levels. Since the programme is targeting both operational (rayon) and systemic (national) levels it is reasonable to infer that a general impact on the health system as a whole should be felt. However the programme is likely to have most impact on the public health services at the local level aiming to benefit at least two thirds of the Georgian population by preventing communicable diseases (including vaccine-preventable diseases). It should be possible to track key progress against outputs at rayon and facility levels and thereby track the extent of achievement at output level of GAVI HSS efforts through progress reports. The program also aims to improve the quality and efficiency of public health interventions through the introduction of supportive supervision and improvement of management skills of public health specialists at the district level. Output level indicators have been included to capture quantitative progress (e.g. no. of supervisory visits completed) however it is not clear in the existing results framework that outcome or any qualitative observations will be captured through existing results framework in this respect.

Most of the indicators will be reported on through programme reporting and the key impact indicators are reported on through National reporting mechanisms and UNICEF's MICS report

on an annual basis. Therefore tracking annual progress of the three core indicators should be straightforward. However, it will be very difficult to attribute success in outcome/ impact indicators to GAVI HSS efforts as insufficient logical links have been made between GAVI HSS outputs and the higher outcome/impact level.

3.8 GAVI HSS Sustainability issues

Sustainability was used as one major criterion for the selection of the GAVI HSS support options. The important majority of GAVI support is an investment in human resources and capacity building of critical public health services therefore the intervention does promise to contribute to the sustainability of health care provision (unless Georgia experiences a very high turnover of medical personnel at the PHC level and public health specialists at the district level).

3.9 Does HSS funding help improved equity

It is difficult to say whether or not GAVI HSS in Georgia is improving equity. Since its interventions are targeting population coverage at district and facility levels it is reasonable to expect that immunization coverage for some of the hardest to reach populations may be improved. However, GAVI HSS in Georgia did not set out to specifically target under-served or minority groups within society.

Annex 1 List of References

HSCC minute of meeting 30_01_07_doc and Signatures

ICC minutes of meetings (3) + ICC profile

Clarifications to the Georgia HSS proposal, May 2007, MoLHSA

cMYP 2007-2010

Review of the Health Sector, WB, June 2004

Immunization Programme Management Review, July 2006

HSS Support program Georgia, Program document, January 2007, MoLHSA

HSS Budget, MoLHSA

Ministry of Health Medium Term Action Plan (2007-2010)

MTEF for 2007-2010, Georgia, MoLHSA

National Health Policy Document 1999

Economic Development and Poverty Reduction

National Health Sector Strategic Plan, Draft, undated

Annex 2 List of People interviewed

1. Tamara Sirbiladze, Medical Project Officer USAID/Caucasus Humanitarian Response Office, Member of ICC
2. George Khechinashvili, WHO Country Officer, Member of ICC
3. Rusudan KlimiaShvili, Liaison Officer WHO, Member of ICC

Annex 3 Description of the study approach

The GAVI Alliance HSS Evaluation Study Approach

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

There are five main objectives and areas of evaluation:

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

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

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