GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Honduras Desk-based Case Study

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Table of Contents

Acronyms and Abbreviations

AIEPI:	Integrated Management of Childhood Illness
AMHON:	Association of Municipalities of Honduras
BPHS:	Basic Package of Health Services
CCIS:	Inter-agency Health Cooperation Committee
CCNI:	National Immunizations Advisory Committee
CONCOSE:	Advisory Council to the Secretariat of Health
CONSALUD:	National Health Council
DTP3	Diphtheria, Tetanus and Pertussis vaccine
ENCOVI:	National Life Condition Surveys
ENDESA:	Demography and Health National Survey
ENESF:	Epidemiology and Family Health National Survey
EPI:	Expanded Program for Immunization
GAVI:	Global Alliance for Vaccines and Immunization
HDI:	Human Development Index
HSS:	Health Services Strengthening
HSCC	Health Sector Coordinating Committee
ICCEC:	Integrated Care for Children with an Emphasis in the Community
IEC:	Information, Education and Communication
OAP:	Operative Annual Plan
PAHO:	Pan American Health Organization
PHC:	Primary Health Care
PRIESS:	Institutional Reform and Coverage Expansion Program of the Secretariat of Health
PRS	Poverty Reduction Strategy
UNICEF:	United Nations Children's Fund
UPEG:	Management Planning and Evaluation Unit
WHO:	World Health Organization

Summary of key findings and recommendations

The main goal of GAVI HSS in Honduras is to strengthen primary health care; with an emphasis on integrated maternal and infant health promotion and prevention services in 104 (119 in the original proposal) priority municipalities. These municipalities were chosen based on health indicators, especially immunization coverage. The focus of the proposal is on the implementation of innovative strategies such as *Integrated Care for Children in the Community* (ICCEC) and the extension of coverage through the delivery of a basic package of health services. The proposal states that it will also focus on complementary strategies such as improving basic equipment, consolidating monitoring, supervision and evaluation processes, (including information subsystems), as well as strengthening communication, surveillance and quality assurance mechanisms.

The HSS proposal design was a highly participatory, open and transparent process led by the Unit for Planning and Development (UPEG) from the Health Secretariat of Government of Honduras. It was also based on a thorough process that identified barriers to immunisation.

While the letter of approval was sent by the GAVI Secretariat in November 2007 the first tranche of funds was only received 9 months later, in August 2008, for unknown reasons. This delayed the beginning of HSS implementation. Start up was also slow because new accounting and financial accountability systems were to be developed by the Planning Unit of the Health Secretariat (UPEG - the HSS coordinating unit) for HSS funds to be transferred to the 20 regional health directorates responsible for implementation. These reviewers were surprised that a small HSS grant worth $2.5 million over 4 years should take so long to set up and that it should involve considerable transactions costs. PAHO sources explained that the centralised government structure and management systems had made the setting up of the Honduras HSS proposal more challenging, in contrast to the Nicaragua proposal where the SILAIS (District Health Systems) enable a more decentralised design and approach.

It will be very challenging to spend the HSS funds with so many spending units involved, particularly since the weakness of the UPEG in terms of implementation capacity are

well known and were reported in the initial exercise identifying barriers to immunisation. There is no discussion in the HSS proposal why - given all these factors - a more simple implementation and monitoring structure was not selected; one using perhaps existing financial management systems instead of new ones being required.

Honduras submitted its first APR containing an HSS section this year covering the period from September 2008 until April 2009. Therefore it is not possible to make any assessment of progress to date. In any case monitoring progress will be extremely challenging in future given the fact that there are 20 implementation sites each responsible for 22 HSS Activities. All reporting will be made in parallel to government systems. We also consider the current monitoring framework unnecessarily heavy and unrealistic as it involves, among other requirements, to conduct baseline surveys in 104 municipalities to measure HSS grant results (even if according to PAHO sources the surveys will be useful for other programmes too).

Even if the APR covers too short a period for evaluating implementation to date we have tried to assess whether the commitment made by the Honduras government to contribute 10% of the grant value to the HSS proposal had been honoured. These commitments are more or less standard government procedure in externally funded projects in Honduras. The APR and then PAHO confirmed that the said transfer has not been made yet; which may affect grant supervision in country as government counterpart funds intended to cover this supervision.

There has been good quality, practical technical support provided by WHO/PAHO for the development and early implementation of the HSS grant.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Honduras in 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 that 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 from 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 2.

1.2 Brief conceptual framework of the Evaluation

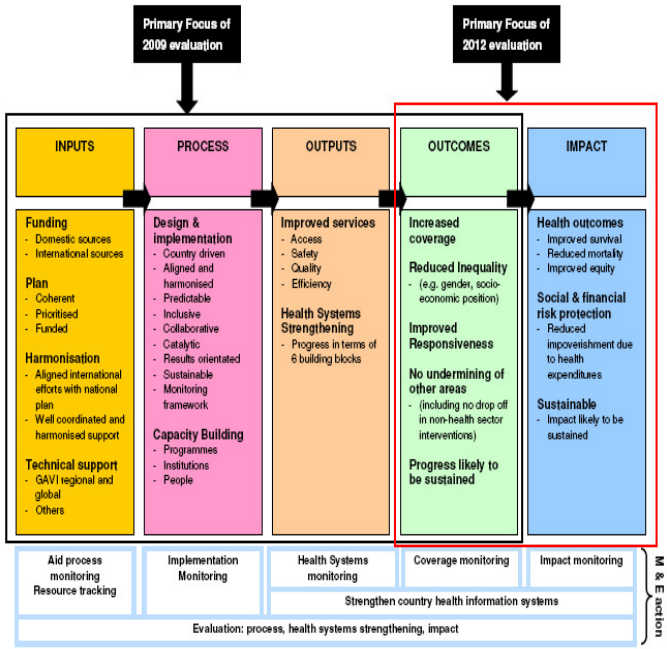
This evaluation is being conducted to inform three areas of decision making:

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 below.

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?

The Honduras Desk Study used a combination of document review with 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 early July 2009. Because of the delicate political situation prevailing in Honduras at the time of this consultation it was decided not to attempt to approach staff from the MOH or donor community. Dr Claudia Castillo (Focal Point GAVI) and Dr Mario Cruz Penate (Focal Point HSS) from the Pan American Health Organisation (PAHO) office in Washington D.C. were extremely kind to provide suggestions for the study and to respond to our questions. We express our thanks to them for being so helpful and for collaborating with this evaluation in spite of the short notice.

The main documents used in the preparation of this Desk Study included:

- The Honduras HSS proposal Submitted in October-November 2007;
- The IRC comments of November 2007 to the resubmitted proposal;
- The IRC consolidated comments to the HSS proposals submitted in 2007
- The APR 2009 (covering 2008)

2 Inputs, outputs and progress to date

2.1 HSS proposal design

The Honduras HSS proposal was coordinated by the Health Secretariat (equivalent to the Ministry of Health in Honduras) through its Planning and Evaluation Unit (UPEG). The proposal design was a participatory process that was triggered in October 2006 by the EPI technical team. Following approval of the initiative to submit a proposal by its Advisory Council (CONCOSE) the Health Secretariat submitted the driving ideas of the HSS proposal to the CONSALUD in December 2006. The CONSALUD is the Honduras equivalent to a health sector coordination committee.

In January 2007 a 21-member multidisciplinary sector working group was established to prepare the proposal. By February it had been decided that the HSS proposal would target 13 high priority departmental regions including 172 municipalities. By the end of that month a national workshop for the review, validation and adaptation of the country HSS proposal had been held with the departmental teams. Then, following national consultations a regional PAHO workshop was held in Honduras in Mach 2007. Once the CONSALUD had given the final approval, the HSS proposal was submitted to the GAVI on the 10 May 2007.

As can be seen the HSS proposal was driven by the government and involved considerable consultation with both public and civil organisations that included the Honduras Medical Association, The Hondurean Council for Private Enterprise, the National Association of Pharmacists and Chemists, the Unions of Health Workers, and several bilateral agencies, among others.

2.2. HSS application and approval processes

The Honduras first HSS proposal was submitted to the GAVI in May 2007. It received a conditional approval by the IRC, whose members pointed to a number of areas in need of additional work. There were a total of six (6) “Conditions” and two (2) “Clarifications” requested by the IRC in the first submitted proposal. Conditions required, for example, a higher degree of specificity on the nature of the “innovative strategies” that the proposal

said would be used, or greater congruence between the budget items and the activities described in the proposal.

By September 2007 a national workshop had been held to prepare an addendum to the proposal in response to the observations made by the IRC. Then, in October 2007 a revised proposal was submitted that received an "approval with clarifications" rating.

2.3 Proposal Focus and rationale

The main purpose of this GAVI HSS application is to strengthen primary health care with an emphasis on integrated maternal and infant health promotion and prevention services in 104 (119 in the original proposal) priority municipalities chosen based on health indicators, especially immunization coverage. In order to achieve this goal the proposal will focus on the implementation of Innovative strategies such as *Integrated Care for Children in the Community* (ICCEC) and the extension of coverage through the delivery of a basic package of health services. The proposal states that it will also focus on complementary strategies such as improving basic equipment, consolidating monitoring, supervision and evaluation processes, (including information subsystems), as well as strengthening communication, surveillance and quality assurance mechanisms.

Defining the HSS objectives and activities was triggered by an exercise where the main barriers to immunization were identified and linked to what would become the main objectives of the proposal and the means for verification of progress. This is summarized in Table 1 below.

Table 1 Barriers, Objectives and Indicators

Barriers	Objectives	Output Indicators
1. Limited managerial capacity in health at the local levels for the development of integrated actions.2. Insufficient quality control of information for maternal and infant health programs.	1) To develop the health management capacity at the local levels to strengthen maternal and infant care in the 119 prioritized municipalities.	Percentage of municipalities with maternal and infant health plans included in the municipal development plan. (Objective 1) Percentage of human resources at the local level trained in management. Percentage of human resources trained in health information systems and use of forms for maternal and infant care.

3. Non implementation of the BPHS delivery strategy including Integrated Care for Children in the Community (ICCEC) in 100% of the HU in the municipalities at risk and with the highest level of social exclusion.	2) To guarantee the delivery of the maternal and infant basic package of health services (BPHS-MI), at least four times per year, in the 119 prioritized municipalities. 3) To extend and to implement the ICCEC strategy of in the 119 prioritized municipalities.	Percentage of municipalities that received at least four BPHS-MI per year in the 119 municipalities prioritized. The proportion of pregnant women that received at least four prenatal control visits. Percentage of communities implementing ICCEC. Percentage of children with growth and development monitoring.
4. Nearly 30% of the Health Units remain closed for more than 60 days of the year due to vacations, trainings, licensing and other reasons; which hinders the delivery of immunization services and/or the basic package of health services.	2) To guarantee the delivery of the maternal and infant basic package of health services (BPHS-MI), at least four times per year, in the 119 prioritized municipalities.	Percentage of HU offering services in a continuous manner throughout the year.
5. Non compliance with the maternal and infant health norms due to lack of monitoring and evaluation. 6. Weak monitoring and evaluation capacity.	5) Support the strengthening of monitoring, supervision and evaluation of maternal and infant health services at the different levels of the services network.	Percentage of HU supervised 6 times per year. Percentage of municipalities that carry out at least 4 evaluations per year.
7. Weak supervision capacity due to lack of logistical support (vehicles, per diems, etc.). 8. Insufficient equipment for the provision of maternal and infant health services. 9. Lack of refrigerated cars for the distribution of biological materials at the national level.	4) To provide the necessary basic equipment for the provision of maternal and infant services, as well as to strengthen the capacity to transport personnel and vaccines.	The proportion of HU at the municipal level with the basic equipment necessary for maternal and infant care.

The priority activities for the achievement of the objectives above and the budget requests are summarized in the Budget Summary Chart below. In all US$2,534,639 was requested over a four year period.

In addition to the HSS funds the Honduran government committed to an additional contribution of US$253,463 (i.e. 10% of the HSS budget) to the HSS grant, as is customary for all externally funded projects in Honduras.

Budget Summary Chart

Objective	Activities	Amount
Objective 1	1.1. Capacity-building activities; 1.2. Elaboration of local plans; 1.3. Inclusion of local plans in the municipal plans; 1.4 Assessment of the adequacy of information subsystems; 1.5. Acquisition of hardware and software equipment.	75,000 13,000 0 13,000 278,639
Total Objective 1		379,639
Objective 2	2.1. Develop a baseline; 2.2. Recruitment (closed HU); 2.3. Programming of BPHS; 2.4. Implementation strategy; 2.5. Delivery of BPHS; 2.6. Health Campaigns.	60,000 228,000 22,000 50,000 312,000 70,000
Total Objective 2		742,000
Objective 3	3.1. Identification of intervention areas; 3.2. Training of community leaders; 3.3. Monitoring.	22,000 100,000 55,000
Total Objective 3		177,000
Objective 4	4.1. Purchase of basic equipment; 4.2. Purchase of vehicles; 4.3. Purchase of thermic cars; 4.5. Maintenance.	341,000 321,000 70,000 35,000
Total Objective 4		767,000
Objective 5	5.1. Tools and methodologies; 5.2. Annual M&E Plan; 5.3. Supervision; 5.4. Evaluation.	10,000 15,000 129,000 75,000
Total Objective 5		229,000
Management costs		100,000
M&E support costs		50,000
Technical support		90,000
GRAND TOTAL		**2,534,639**

2.4 M&E, Annual Progress Reporting (APR)

While the letter of approval was sent by the GAVI Secretariat on November 2007 the first tranche of funds were only received 9 months later, in August 2008. This delayed the beginning of HSS implementation until September 2008. Second and third factors for delayed start up were the new, parallel and HSS specific administration procedures

associated with the HSS grant, together with the decentralised nature of HSS implementation; with 20 regional health directorates gathering information from 104 municipalities.

Given the above, the APR report submitted in May 2009 by Honduras only covered 3 months of 2008 (September-December) and 4 months from 2009 (January to April). This means that too little time has elapsed for assessing HSS progress even at activity level since most of the time has been used for start up measures. These are also the main reasons why project expenditure in the reporting period reached a mere 16% of the $607,000 received from the GAVI for FY1.

Given the decentralised nature of the HSS proposal it is going to be challenging to monitor progress, not only at activity level (through a cascade or reporting requirements) but also at the level of outcome and HSS progress indicators. Particularly since most of the arrangements for setting up the monitoring framework were not yet ready 7 months after start up of HSS. Our impression is that the monitoring framework is more adequate in terms of attribution and sensitivity of indicators than many HSS proposals that we have seen. However it will be extremely difficult to operationalise such an ambitious monitoring framework. In fact, the anticipated undertaking of baseline surveys in 104 municipalities in order to be able to monitor the impact of HSS funds seems completely disproportionate to an intervention worth $3.5million over 4 years.

HSS Progress Indicators in the Honduras HSS Proposal

Outcome Indicators

- The under-five mortality rate.
- The infant mortality rate.
- The maternal mortality rate.
- The percentage of immunization coverage. Especially DTP3 at the national level, as well as the percentage of departments that reach a coverage rate with DTP3 higher than 80%.
- The percentage of MMR immunization coverage in children 12-23 months of age.

Process indicators:

- The percentage of municipalities with maternal and infant health plans included in the municipal development plans. (Objective 1)
- Percentage of municipalities that received at least four BPHS per year in the 119 municipalities prioritized. (Objective 2)
- Percentage of communities implementing ICCEC. (Objective 3)
- The proportion of Health Units (HU) at the municipal level with the basic equipment necessary for maternal and infant care. (Objective 4)

- The proportion of pregnant women that received at least four prenatal control visits. (Objective 2)
- Percentage of children with growth and development monitoring. (Objective 3)
- Percentage of HU supervised at least 6 times per year. (Objective 5)

It will also be very challenging to spend the funds with so many spending units involved, particularly given the known limited implementation capacity of the Health Secretariat in Honduras; reported itself as a barrier to immunization in the HSS proposal. There is no discussion in the HSS proposal around why - given all these factors - a more simple implementation and monitoring structure was not selected.

There are three issues that the APR writers have discussed in the 2009 reports that should receive close attention in the coming months and years, as follows:

a) *Systematic steps for monitoring progress, supervision and evaluation at the national, departmental and local levels as defined in the proposal have not been performed.*

b) *The PAHO/WHO HSS focal point in Honduras was transferred to another country; in consequence the technical support that was continuous before was interrupted some weeks ago.*

c) *This is Honduras' first experience in the preparation of an APR to GAVI. The country's reporting system is based on the fiscal year from January to December. Due to the different timing of the HSS grants and late receipt of HSS funds the first operational plan was developed from August 2008 to September 2009 but activities only started in November 2008.*

2.5 Progress to date

For all the reasons mentioned above it is not possible to assess progress to date. However, there are signs that the implementing unit is already experiencing some improvements as a result of HSS funding. The following is mentioned in the 2009 APR report:

1. It is very relevant that the GAVI-HSS Support has enabled the allocation of funds in a more equitable form to the health regions, in accordance with the objectives and activities of the proposal. The official assignation method for budget distribution was used; criteria include health status (impact selected indicators) demographics and access to health services.

2. Update of selected municipalities (This also represents a change of scope in comparison to the proposal, since the municipalities have been decreased from 119 to 104) and detailed selection of communities to be intervened. As mentioned before, the reduction in the number of municipalities originated specially in the results of the annual evaluation for 2008. 15 municipalities have improved some of the indicators used for prioritization. Neglected towns in which interventions were to take place were selected based on their vulnerability using a methodology that assigned priorities and relative weights to the Honduras GAVI HSS Proposal target indicators.
3. For the local level it has been really helpful to have this complementary and synergystic support in addition to funds from other sources.
4. Baseline surveys and analysis have been conducted in the 104 municipalities for future evaluation of progress and impact. A first evaluation will be performed after 12 months.
5. Increments in the mandatory per-diem rates for the public sector will require adjustments in the number of towns that could be intervened with several activities. The new regulations became effective November 18, 2008. (Official Journal La Gaceta 31,764)
6. The rise in the minimum wage impacted the basic salary for auxiliary nurses. The number and duration of Health personnel contracts considered in Activity 2.2 will decrease.
7. Administrative arrangements for implementation produced delays in the first months. Mechanisms have been designed and clarified. The direct transfer of funds from PAHO/WHO to the Regional Health Directorates according to operational plans of operation will start on May 2009 avoiding unnecessary steps and reducing paperwork.

2.5 Support systems for GAVI HSS in Honduras

The Pan American health Organisation has played an important role in helping design the HSS proposal and then in setting up the required administration arrangements and monitoring progress. This is recognized in both the original proposal and in the 2009 APR report. Nevertheless, we asked our PAHO informants why such a complicated proposal had been selected, and whether alternative options for implementation or monitoring could have been considered. According to PAHO it was mainly the centralized nature of the Honduran government and the choice of UPEG as the main

HSS management and oversight unit that generated the need for financial management procedures that might not have been necessary in a more decentralized context. The contrast of the Honduran model with the on operating in Nicaragua, where HSS is implemented through the decentralized SILAIS (District Health Systems) was offered as an alternative model that could not be used in Honduras.

3 Alignment with GAVI HSS principles

Note from the authors: the delicate political situation prevailing in Honduras at the time of this desk review did not allow us to approach any government staff to contrast information presented in this report. We are thankful to Mario Cruz-Penate, the GAVI HSS Focal Point in PAHO Washington for sharing additional information and views with us.

This section will attempt to analyse the extent to which the Honduras 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

The proposal preparation was very country driven and led by the Unit for Planning and Development (UPEG) of the Health Secretariat. There was considerable involvement of the civil society and of private sector organizations in the design; a reflection of an open, inclusive and transparent proposal preparation stage.

3.2. Is GAVI HSS aligned?

Honduras HSS proposal is very much aligned with broader planning and health policies and priorities contained in the National Health Plan 2021 and in the National Health

Policy 2006-2010. Further, the design of the proposal was triggered by a consultation process on barriers to immunization.

Alignment is, however, quite deficient when we consider the separate, parallel activity planning, monitoring, reporting, financing and accounting systems that had to be put in place. Given the relative small size of the HSS proposal ($2.5 million over 4 years) all the above mentioned arrangements appear disproportionate and imply high transaction costs for such a small country like Honduras with so many constraints in terms of planning and management capacity in the health sector. The APR 2009 makes reference in particular to the lack of syncronisation of the GAVI APR with the reporting and fiscal cycle in Honduras.

3.3. Is GAVI HSS Harmonised?

There is no indication in either the original HSS proposal or the APR to enable us to answer this question. In fact, there is little mention made in either document, of financing mechanisms used by other donors in the health sector or about the complementarity of the HSS grant that would enable an assessment of this issue. The HSS grant looks very much like another project to be run and managed by the UPEG, a unit where important capacity issues have been reported over time[1] to which this project would seem to add a considerable burden.

3.4. Is GAVI HSS funding predictable?

The main issue about predictability of HSS funding that we could document was the 9 month delay in Honduras receiving the first tranche of HSS funding, but we could not verify from any source or document the reasons for such a delay.

3.5. Is GAVI HSS accountable, inclusive and collaborative?

So far the Honduras HSS proposal has scored high on these indicators in all that refers to the proposal design and application processes. The HSCC equivalent (CONSALUD) was relatively involved in the proposal design which was also, as mentioned earlier, an open process where other health partners, civil society and private enterprises could and did participate.

[1] See for example the “Health Sector Feasibility Study of Honduras” undertaken by the Health Secretariat in May 2003 or the “EPI Financing and Policies Study” undertaken by the World Bank in January 2005.

It is harder to assess the complementarity of the HSS proposal (as a proxy for collaborative effort with other health partners) since we lack information in the proposal or in the APR about what other donors are doing or funding in relation to HSS. This point was picked up by the IRC when it reviewed the Honduras and seven other HSS proposals in November 2007.

3.6. Does GAVI HSS have a catalytic effect?

The catalytic effect is not obvious from the proposal, although as mentioned in 2.5 the UPEG in the Health Secretariat seems to be of the opinion that the HSS funds are beginning to trigger changes and to help local level service providers access funds that they previously did not have.

3.7 Is GAVI HSS Results Oriented?

The results orientation of the HSS proposal is confounded by what we consider an unrealistic monitoring framework vis a vis the size of the grant. An example of this has been the need to conduct baseline surveys in no less than 104 municipalities (as reported in 2.5) that appears quite disproportionate to the task. Finally, it is admitted in the APR that the process of setting up the HSS monitoring arrangements has not yet begun. Considering all these factors together, demonstrating results of this HSS proposal – at least as per the present framework - is going to be very difficult. In sum, we do not consider this HSS proposal results oriented because for it to be so, the first prerequisite would have been to design a simple, manageable monitoring framework; which has not been the case. In fact, one might even consider that the amount of transaction cost generated by these ambitious monitoring arrangements will be likely to negatively affect the attainment of project results, in terms of increased service delivery and managerial capacity in the 104 municipalities.

3.8 GAVI HSS Sustainability issues

By general standards the Honduras HSS proposal provides considerable attention to sustainability issues. It does say that the following measures will be taken:

1. The National Health Policy 2006 - 2010 gives high priority to maternal and infant mortality reduction, and aims to achieve at least 90% of coverage of maternal and infant health services.
2. The Government will contribute with 10% of the total of donor funds, which will be incorporated in the project in the first year of execution.

3. In the departments and municipalities that have the highest number of closed HU, the Municipal Institutions included the recruiting of at least one itinerant team in their development plans.
4. The Secretariat of Finance together with the Secretariat of Health agreed to sign an "Institutional Cooperation" agreement for the Project "Strengthening of Health Services" to ensure sustainability of the actions implemented by the HSS project.
5. The Government will assign the funds required for the operation of the maternal and infant health services included in the HSS project.
6. The expansion of the Immunization Law, to be approved by the National Congress, will give higher sustainability to the EPI and therefore to the HSS project.
7. The health regions have accepted the responsibility of negotiating with the municipalities to incorporate in the municipal development budgets the acquisition of basic equipment, materials and inputs that guarantee primary care in maternal and infant health.

It is not possible though, for these evaluators to assess at this stage whether the extent of compliance with the points above as there is no reference to it in the APR 2009. In any case, some of the stated commitments would be difficult to verify.

3.9 Does HSS funding help improved equity

The Honduras HSS proposal focuses on 104 municipalities where indicators are worse than in other municipalities, so it could be concluded that it is equity oriented. However the degree to which such a small sum of HSS money has the potential to redress or significantly modify equity issues among municipalities is doubtful. In any case the writers of the APR report seem to be of the opinion that "the GAVI-HSS Support has enabled the allocation of funds in a more equitable form to the health regions, in accordance with the objectives and activities of the proposal". The official assignation method for budget distribution was used, criteria include health status (impact selected indicators) demographics and access to health services.

Annex 1 List of people interviewed

Annex 2 List of documents reviewed

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 as 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.