Consultancy Services for Conducting a Monitoring and Evaluability Study for GAVI’s Health System Support to Countries

Final Report

August 2008

Axios International
Paris, France

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### Acronyms

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CPA</td>
<td>Country Progress Report</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DPT3</td>
<td>Diphtheria Pertussis Tetanus Vaccine</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
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<td>IHP</td>
<td>International Health Partnership</td>
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<td>IRC</td>
<td>Independent Review Committee</td>
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<td>ISS</td>
<td>Immunization Services Support</td>
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<td>KOL</td>
<td>Key Opinion Leader</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NVS</td>
<td>New and Underused Vaccines Support</td>
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<td>SH</td>
<td>Stakeholders</td>
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<td>RCT</td>
<td>Randomized Controlled Trials</td>
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Executive Summary

GAVI needs to assess the success of its investment in health systems strengthening (HSS), in order to determine the future of the initiative and its adherence to the principles outlined in the investment case. The overarching objective of this evaluability study is to present an actionable monitoring and evaluation framework and plan for GAVI HSS. This involves presenting the key evaluation questions for 2009 and 2012; providing concrete recommendations on how they will be addressed and measured; and outlining the key differences between and complementarities of the 2009 and 2012 evaluations; and identifying data needs and monitoring systems strengthening for 2009 and 2012. The key findings and recommendations following from this evaluability study are presented below.

- The impact, effectiveness, and efficiency of the GAVI HSS funding window can be evaluated, within limits, if its contributions and achievements are documented both qualitatively and quantitatively.

- As indicated in the GAVI HSS Investment Case, however, major impacts from the GAVI HSS initiative cannot be expected within the first years of program initiation; rather, progress toward anticipated impacts can be documented, and achievement of program objectives can be tracked.

- The GAVI HSS funding window evaluation faces three essential challenges, as noted in a prior review of HSS proposal quality:
  - HSS proposals encompass a wide range of discrete activities, and it is often not clear how these different activities contribute to project objectives and higher-level program goals
  - Data on the outcomes and impacts of HSS or immunization interventions (including appropriate indicators for measuring these effects) are either scarce or of questionable quality (for instance, all funded countries do not currently track the three primary indicators for the initiative)
  - Health system and mortality change processes are complex and changes may only become apparent years after an activity has been completed.

- The GAVI HSS Evaluability Study notes the following regarding these challenges’ impact on the evaluability of the HSS funding window:
  - **Attribution**: Because of the nature of the complex, multifactoral health systems changes anticipated, the discrete activities supported by GAVI HSS funds, and the overall difficulties in measuring the health impact of HSS interventions, the contribution of GAVI HSS to health systems strengthening, rather than attribution of health systems impacts to GAVI HSS, can be assessed.
  - **Counterfactual**: For both country and global HSS interventions, it is difficult to isolate the intervention from wider institutional and policy environments. In addition, any effects are complex, diffuse and uncertain, making it nearly impossible to
determine appropriate counterfactuals. However, one possible solution to establishing counterfactuals is presented in the recommendations below.

- **Sustainability**: Sustainability is a highly contested concept that is difficult to define in terms of measurable indicators or objectives. Any assessment of the sustainability of GAVI HSS investments and impacts should distinguish between different units of assessment (e.g., institutions, health systems) and different dimensions of sustainability (e.g., financial sustainability, capacity sustainability).

- The evaluation framework presented in this report for GAVI HSS takes a stepwise approach, differentiating the aims of the 2009 evaluation from those of the 2012 evaluation such that they incrementally build on each other.
  - The **2009 evaluation** focuses on five key processes to assess their level of performance, interrelatedness, strengths, weaknesses and potential solutions; these include: proposal design, development and approval process; design and implementation of GAVI HSS-funded activities; management of funds; monitoring and evaluation of activities; possible outcomes of funding support.
  - The **2012 evaluation** expands to include a greater emphasis on actual health systems strengthening and associated outcomes and health impact, denoted quantitatively and by trends.

- **What can be addressed in 2009**: The 2009 evaluation should focus on answering the following key questions:
  1) Has GAVI HSS operated according to its guiding principles?
  2) Has GAVI HSS contributed to any observable health systems strengthening?
  3) What are the strengths and weaknesses of key GAVI HSS processes?

  While health impact and outcomes cannot yet be measured, the 2009 exercise will focus on establishing baselines where needed, and processes for impact data collection for 2012.

- **What can be addressed in 2012**: In 2012, the evaluation should answer the following questions:
  1) Has GAVI HSS contributed to any observable health systems strengthening?
  2) Has GAVI HSS contributed to changes in immunization coverage or under-five mortality?
  3) Which GAVI HSS operated guiding principles most likely affect the effectiveness of the funding?
  4) What strengths and weaknesses of key GAVI HSS processes most likely affect the effectiveness of the funding?
Recommendations

1. GAVI must strengthen the routine monitoring of its HSS funding window, both to support the evaluations in 2009 and 2012, but also to improve its own operations. The following data should be included in routine GAVI HSS monitoring:
   - Systematic tracking of proposal approvals and quality
   - Systematic tracking of financial information, in particular disbursement and expenditures rates
   - All three core outcome and impact indicators, for each GAVI HSS-funded country
   - Key HSS indicators, defined by the three health systems areas suggested by the GAVI HSS guidelines

A detailed discussion of the monitoring data needs is presented in section 3.C of the report.

2. GAVI should develop the evaluation RFP and budgets to include comparison countries a “counterfactuals” – countries that have received GAVI funding, but not HSS, funding. The comparison countries should be matched on:
   - Baseline immunization coverage
   - HSS capacity (as measured by HWs per 1000)
   - ISS $ per capita
   - Population size

More detailed discussions of the counterfactual issues are presented in sections 2.D and 3.C.

3. GAVI should ensure that countries prepare for the measurement of impact in 2009 (baseline) and 2012. In addition, GAVI should consider ensuring that impact is measured in 2015, to assess progress against the MDGs in GAVI HSS-funded countries. Preparation for impact measurement in the HSS and comparison countries should include:
   - Assessment of the quality and timeliness of existing baselines
   - Identification of planned country data collection activities that could include immunization coverage or under-five mortality assessment (e.g. planned DHS)
   - Identification of in-country institutions and capacity for conducting an impact assessment
   - Identification of appropriate external capacity and support for each country

Data collection needs for impact evaluation are discussed in section 3.D.
1. Introduction

A. GAVI HSS

The Global Alliance for Vaccines and Immunization (GAVI) Health System Strengthening (HSS) funding window of US$500 million was established in 2005 to achieve and sustain increased immunization coverage in all GAVI eligible countries. It offers increased flexibility to support HSS, with closer integration and alignment to in-country national health plans and strategies; enhanced partner engagement; and expanded capacity building at country level. This approach was devised to help achieve the overall GAVI objective that by 2010 all GAVI eligible countries would have routine immunization coverage at 90 percent with at least 80 percent coverage in every district\(^1\). Its focus on health systems also aims to achieve the GAVI milestones for hepatitis B, Hib vaccination and a polio-free world.

In contrast to traditional vertical health funding, the HSS window provides horizontal, innovative, flexible and predictable long-term financing. Rather than a project-based initiative, this GAVI HSS aims to add value to immunization-focused projects. In its investment case, it suggests three main areas of focus: (i) health workforce, (ii) drugs, equipment, and infrastructure supply, and (iii) the organization and management of health services. All 70 GAVI-eligible countries are qualified to apply under the HSS window. Since the first round of funding was awarded in November 2006, 40 countries (55 percent) have applied and thirty countries (40 percent) have been awarded funds.

GAVI needs to assess the success of its investment in HSS, in order to determine the future of the initiative and its adherence to the principles outlined in the Investment Case. As anticipated from the Investment Case, “it is crucial that funders of GAVI are made aware from an early stage that they cannot expect major outcome results after a couple of years”\(^2\). Many partners and countries feel it is too soon to measure the impact of the GAVI HSS investments. They contend that outcomes and impact may not be evident before 2010. The risk is that in 2009, GAVI Alliance funders will not see the value of the HSS investment. It is therefore essential that progress in HSS be captured, albeit not necessarily in impact or outcome indicators.

This evaluability study proposes a monitoring and evaluation (M&E) plan for GAVI HSS. Essentially, it recommends that the 2009 evaluation focus primarily on processes and experiences along with any available quantitative data, that it assesses progress against output indicators, and that it provides concrete recommendations for the 2012 evaluation. The study also proposes that the 2012 evaluation expand to include a greater emphasis on actual health systems strengthening and associated outcomes.

\(^1\) GAVI (2003) Tenth GAVI Board Meeting, New York City, 6 March 2003. Final Summary Report
\(^2\) See Proposal for GAVI to Invest in Health Systems Strengthening, 10 November 2005, page 28,
B. Objectives of the Evaluability Study

The overarching objective of this evaluability study is to present an actionable M&E framework and plan for GAVI HSS. This involves presenting the key evaluation questions for 2009 and 2012; providing concrete recommendations on how they will be addressed and measured; and outlining the key differences between and complementarities of the 2009 and 2012 evaluations; and identifying data needs and monitoring systems strengthening for 2009 and 2012.

This study report is organized as follows. A second section provides the background of the GAVI HSS evaluability study; outlines the methodological approach taken to develop the proposed M&E plan; discusses how the common M&E plan, proposed by the International Health Partnership (IHP), can be operationalized for the GAVI HSS evaluations; and outlines the key challenges to operationalizing the conceptual framework and measuring HSS impact. A third section proposes an M&E plan for GAVI HSS. Here an actionable M&E approach outlines key evaluation questions, suggests appropriate indicators and recommended data sources. A final section provides key recommendations.

2. Approach to Assessing Evaluability

A. Background

The GAVI Alliance HSS funding window serves the overarching objective of achieving and sustaining increased immunization coverage by strengthening the capacity of the health systems to provide immunization and other health services (with a focus on maternal and child health). In 2005, the GAVI Alliance Board agreed to two comprehensive evaluations, with the aim of better understanding how and to what extent this objective is achieved.

In preparation for the first major evaluation to be conducted in 2009 GAVI has commissioned an evaluability study to recommend an actionable approach of evaluating the HSS funding window. As outlined in the original request for proposals, the purpose of this study is to provide GAVI with a suitable M&E framework for its Health System Support. The objectives of the evaluability study were listed as:

- Assess the current monitoring system and propose changes to ensure a suitable monitoring framework for the GAVI HSS. This framework will have to take into account the evaluation questions that will need answering.
- Identify the key data required to be collected for a baseline, the appropriate starting point for a baseline and, if necessary, approaches to “reconstruct” it
- Identify the questions for the evaluation to be conducted by 2009
Identify evaluation studies that should be carried out before 2009 and prepare the questions to be answered
Identify the most suitable evaluative approaches (both formative and summative)
Identify how to establish an appropriate counterfactual.
Provide cost estimates for the construction of a comprehensive baseline, ongoing monitoring and evaluation studies.
Provide a strategy for the implementation of the M/E activities

**B. Methods Used in Evaluability Study**

To design the M&E plan of the GAVI HSS funding window four steps were involved. These include:

1) Key Opinion Leader (KOL) and stakeholder (SH) interviews, complemented by a desk review in order to understand the context and priorities of the GAVI HSS funding window
2) An evaluation framework to identify the key evaluation questions that ideally should be addressed at both the country and organizational level
3) An operationalization of the evaluation framework to provide recommendations on specific details to be include in the 2009 and 2012 evaluations
4) In this study report, an actionable M&E plan is proposed that takes into account all of the above, and considers GAVI’s readiness to implement and support the plan

These steps are depicted in Diagram 1, and further described below. It should be noted that the assessment of existing M&E systems for the GAVI HSS funding window was a continuous process through all four steps, and is explicitly taken into account in this study.

**Diagram 1. Approach to GAVI HSS Evaluation Plan Development**
i. **Step 1: Desk Review, Key Opinion Leader and Stakeholder Interviews**

The results of the first step of this evaluability study were recorded in an inception report that contains the preliminary findings from the desk review and the KOL and SH interviews. In summary, respondents praised GAVI HSS’ funding window for its innovative design, flexibility and inclusiveness. Six priorities were emphasized for inclusion in the evaluation framework:

1. Measuring country progress in HSS implementation
2. Assessing the grant application process for efficacy, efficiency, simplicity and country participation
3. Evaluating the effectiveness of technical assistance
4. Reviewing the GAVI Alliance governance
5. Assessing whether GAVI HSS has adhered to its principles
6. Identifying ways to strengthen the HSS learning process.

(See Annex C for the complete report from Step 1)

ii. **Step 2: Evaluation Framework and Questions**

Results from the inception report provided the basis for Step 2. The team identified key evaluation questions that would shape the evaluation framework. These were organized according to five key process steps used for accessing and using GAVI HSS funds. These key process steps were:

1. Proposal design, development and approval process
2. Design and implementation of GAVI HSS-funded activities
3. Management of GAVI HSS funds
4. Monitoring and evaluation of GAVI HSS-funded activities
5. Possible outcomes of GAVI HSS funding support

Here, data challenges and concerns were also identified. These included existing data not being organized for systematic monitoring; the need to evaluate country progress according to the round of implementation; and the need to establish evaluation methods across countries with very different capacities and contexts. (See Annex D for the complete report from Step 2.)

iii. **Step 3: Operationalizing the Evaluation Framework**

The key evaluation questions were then operationalized into a strategic evaluation framework for GAVI HSS. This report took into consideration the KOL and SH interviews as well as country specificities. It also focused on the capacity of the funding window to improve HSS at both a national and a global level. (See Annex E for the complete report from Step 3.)

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3 Each country has developed activities according to their specific context, therefore GAVI HSS funded activities vary from country to country.
iv. Step 4: Monitoring and Evaluation Plan

This study report provides an actionable M&E plan for GAVI HSS. It includes key evaluation questions, recommends practical indicators and data sources, and identifies data and monitoring needs for 2009 and 2012.

C. Conceptual Framework for the GAVI HSS Monitoring and Evaluation plan

i. International Health Partnership’s Common Monitoring and Evaluation Framework

The common monitoring framework proposed by the International Health Partnership (IHP) forms the basis for the proposed M&E plan. The IHP framework is a common framework for monitoring performance and evaluation. It aims to provide model for well-coordinated efforts to monitor and evaluate progress and results in country. This framework provides GAVI Alliance and other donors with a common platform for monitoring the outcomes and impact of their investment in health systems.

Diagram 2 illustrates this framework. The upper row represents the general sequence used in M&E frameworks. It begins with inputs and processes and continues to outputs, outcomes and impact. The lower part of the diagram shows the proposed actions for monitoring performance and evaluation. How this framework can be operationalized for GAVI HSS is discusses in the following section.

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5 Minutes from the GAVI Alliance & Fund Board meeting (25 & 26 June 2008) ; IHP Briefing Note: A common framework for monitoring performance and evaluation of the scale-up for better health (accessed July 2008: http://www.who.int/healthsystems/IHP_M&E_briefing_30_Jan_2008.pdf)
Diagram 2. Framework for monitoring performance and evaluation of the scale-up for better health

ii. How the IHP Framework can be Operationalized for GAVI HSS Monitoring and Evaluation

1. Inputs and processes
The left side of the diagram lists domestic and international inputs and processes. When applied to GAVI HSS inputs may include funding for proposal development, technical assistance and resources for HSS, as well as better planning represented by the activities outlined in proposals or the harmonization of these activities and funding flows with national plans and international efforts.

These inputs should lead to better processes that adhere to GAVI principles. For example inclusive and collaborative proposal development, sustainability-conscious capacity building, predictable funding and aligned monitoring systems.

2. Outputs
The central section represents the expected outputs resulting from improved implementation of the national health sector plans and additional GAVI HSS funded activities. For GAVI HSS, expected outputs may include improvements in key three areas:

1) health workforce mobilization, distribution and motivation targeted at those engaged in immunization and other health services at the district level and below
2) drugs, equipment and infrastructure supply, distribution and maintenance for primary health care
3) the organization and management of health services at the district level and below (including financing issues)\(^6\)

Countries receiving GAVI HSS funding monitor outputs through six indicators, specifically defined for their context\(^7\).

### 3. Outcomes

All countries receiving GAVI HSS funding are expected to experience an increase in immunization coverage as a result of increased outputs of the national health plans. Possible outcomes include improved access to primary health services from targeted HSS activities; greater equity in immunization coverage and greater quality in service delivery through targeted funding; greater efficiency in service delivery through targeted HSS activities; increase in national Diphtheria Pertussis Tetanus vaccine (DTP3) coverage; increase in the number or percentage of districts achieving ≥80% DTP3 coverage. Other outcomes may include any unanticipated effects of GAVI HSS on donor coordination and participation, district/operational level functioning, beneficiary/community level perspectives, or on countries’ health information systems.

### 4. Impact

In the case of GAVI HSS, the increased immunization coverage is expected to improve infant and maternal health. Impact monitoring of the GAVI HSS funding window currently entails collecting under five mortality rates (per 1000), by country.

### D. Methodological Challenges to Operationalizing the IHP Conceptual Framework and Measuring HSS Impact

As part of assessing whether the GAVI HSS success can be measured, we explore below some of the methodological challenges that any effort to measure the impact of HSS interventions face.

Specific to GAVI, the methodological challenges to impact evaluation stem from the fact that:

- HSS proposals encompass a wide range of discrete activities, and it is often not clear how these different activities contribute to project objectives and higher-level program goals\(^8\)
- Data on the outcomes and impacts of HSS or immunization interventions (including appropriate indicators for measuring these effects) are either scarce or of questionable quality\(^9\)
- Health system and mortality change processes are complex and changes may only become apparent years after an activity has been completed.

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\(^6\) GAVI (2005) Investment Case.
\(^7\) Annual Progress Report represented in the GAVI 2008-2010 strategy
\(^8\) IRC comments; Assessment of the Quality of the Results Frameworks of GAVI HSS proposals, 22 Feb 2008
\(^9\) Assessment of the Quality of the Results Frameworks of GAVI HSS proposals, 22 Feb 2008
These constraints, as well as the inherent complexity of linking country-specific interventions to global HSS, immunization or mortality gains, pose particular methodological challenges to impact evaluations of any HSS initiative. The particular challenges of attribution, the counterfactual problem, and challenges to assessing sustainability, are discussed in more detail below.

i. Attribution

The GAVI HSS evaluation is essentially concerned with two issues; first, what has happened (in a descriptive sense) and second, the causal relationships between the specific GAVI-funded HSS interventions and the changes in immunization coverage and under-five mortality rates. These constitute the core of the attribution challenge – that is, uncovering the effects of an intervention on particular phenomena, while taking into account the influences of other pertinent variables.

The primary objective of the GAVI HSS funding window is to generate global immunization and child health benefits. Therefore, the effects of all GAVI HSS-funded interventions should ideally be traceable up to these primary aims – for example coverage rates, equity in coverage and under-five mortality. However, if the GAVI HSS evaluation were to concentrate only on impact at these levels, its utility would be severely hampered by the substantial challenges of attribution\textsuperscript{10} and aggregation\textsuperscript{11}.

More specifically the following complicating factors play a role:

1. The concept and measurement of health systems capacity/strengthening.

GAVI, like many other global HSS initiatives, is following WHO’s definition of health systems, which includes six building blocks which include governance, financing, human resources, information systems, medical products, and service delivery\textsuperscript{12}. Health systems capacity and performance as a whole, as well as the six building blocks, cannot be easily captured by simple indicators. Rather, they require multiple indicators representing different components of the health system and each building block\textsuperscript{13}. Comprehensive indicators are often contested as they are clearly value-laden and often involve adding up different aspects of health systems performance, which in some cases may be negatively correlated.

2. Current data availability.

A major input to impact evaluation studies is the existing information base. As a result, evaluators first of all inquire whether there is useful existing evaluative evidence (at implementation level) to inform impact evaluation studies. Second, the question arises as to how existing evaluative evidence (at implementation level) can be usefully aggregated to inform impact assessment at the global level. In

\textsuperscript{10} Attribution: establishing to what extent immunization coverage and child mortality changes can be shown to result from GAVI HSS-funded interventions

\textsuperscript{11} Aggregation: the extent to which localized immunization and child health status changes, resulting from GAVI HSS-funded interventions, can possibly be seen to contribute to higher-level global changes


\textsuperscript{13} Recent work (2008) by the Health Metrics Network to develop a dashboard of HSS indicators proposes from 1 to 6 indicators for each of the six building blocks, many of which are themselves composite indicators.
the case of GAVI HSS, it has been found that proposals do not have standardized reporting on core impact and outcome indicators\textsuperscript{14}.

3. **Blending of financing and interventions.**

One of the ten GAVI HSS guiding principles emphasizes that GAVI HSS funding should be harmonized; another emphasizes the catalytic role of the GAVI HSS funding window. Some of the key mechanisms through which these effects have been expected to occur are: fostering awareness and political will to act on child health and immunization concerns; fostering institutional alliances and partnerships among public and private actors; building capacities; supporting operations research to build knowledge on HSS; and demonstrating and disseminating best practices on innovation. This blending of interventions, levels of activities, and financing presents particular challenges when trying to attribute effects to GAVI HSS, or determine causality.

**ii. A Way to Map Causality of GAVI HSS Interventions**

The causal pathways from basic health interventions that involve a specific behavioral change activity or medical technology are often very complex. For health systems interventions, which often combine behavior change and medical technologies with management and financing changes, causal pathways can become so complicated as to be almost obscure. The causal pathways of the discrete HSS interventions funded by GAVI may be more or less clear depending on the exact nature of the intervention.

In some cases the links between certain interventions, HSS, and improvements in immunization coverage are somewhat straightforward and attribution issues can be resolved relatively easily\textsuperscript{15}. In other cases, one can only assume that there is a positive causal link between HSS and immunization coverage on the basis of existing evidence. In the worst case, causality is highly contested because the current state of the art of knowledge about linkages between health systems capacity and increased and sustained immunization is insufficient to draw conclusions about causality and attribution. For example; training more primary health care workers leads to increased immunization coverage or improved quality of services\textsuperscript{16}.

**iii. Establishing a Counterfactual**

“Rigorous impact evaluation” is mostly equated with randomized controlled trials (RCTs) or close derivatives, mainly quasi-experiments. The core idea is that observed changes can only be interpreted if they are objectively compared to a counterfactual situation\textsuperscript{17}. Randomization in any type of social policy, and in particular with health interventions with known benefit, is often, simply, not possible.

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\textsuperscript{14} Assessment of the quality of GAVI HSS Results Frameworks, 22 Feb 2008

\textsuperscript{15} For example, the link between a documented increase in the number of facilities providing immunization and national coverage rates.


\textsuperscript{17} Counterfactual: that which would have happened without the intervention.
(people cannot be excluded at random) or unethical to implement (withholding benefits from particular people while providing them to others).

The result is that impact evaluation studies in health are mostly of a quasi-experimental nature, when they are done at all. Quasi-experimental evaluation requires careful planning from the start of an intervention, enabling an adequate study design as a basis for reliable baseline and post data, as well as identification of appropriate control or comparison groups when possible. The strength of quasi-experimental evaluation design lies in the selection of control groups at the time of intervention implementation and the extent to which it is possible to match groups on key factors that can influence the outcome of interest.

With broad HSS interventions, the challenge is to identify, ex ante, all the possible factors that can influence an outcome some distance from the intervention – the range of confounding factors can often require larger sample sizes and expanded data collection activities. This is one of the reasons that quasi-experimental impact evaluation can be very costly and time-consuming. For example, the World Bank, since 1980 has conducted only 23 of this type of evaluation with costs ranging between US$ 200,000 and US$ 900,000, and taking often more than two years to complete. The technical and practical challenges to doing this type of evaluation, including the high demands in terms of statistical analysis skills, and planning and organization of evaluation designs, often goes beyond local capacity. Another constraint concerns the fact that impact evaluations may not coincide with regular planning cycles and are often commissioned ad hoc. These constraints limit the possibility of including, from the outset of the intervention, appropriately “designed” counterfactuals.

In addition, GAVI HSS interventions directed at awareness building, health services management systems, capacity building, political support at national or regional level, as well as other catalytic effects central to GAVI’s role in supporting global HSS and Millennium Development Goals (MDGs) cannot be adequately assessed on the basis of quasi-experimental designs. These interventions and their intended effects are completely different from the relatively well-delineated, country-specific HSS interventions with clearly identifiable targets which usually are the subject of quasi-experimental impact evaluation. For both country and global HSS interventions, it is much more difficult to isolate the intervention from the wider institutional and policy environment. In addition, any effects are complex, diffuse and uncertain, making it nearly impossible to determine appropriate counterfactuals.

Without appropriate counterfactuals, of which there are few options, the attribution of observed changes in the three core outcome/impact indicators to GAVI HSS interventions is unlikely to be realistically possible. It is preferable to think about contribution instead of attribution, which basically entails a more comprehensive perspective on causality, and does not try to make claims regarding the precise path and magnitude of the causal effect from the intervention to change in outcome or impact indicators. With a “contribution, not attribution” approach, hypothesizing about causal relationships.

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between HSS interventions and core outcome and impact indicators changes is important, but the evaluation needs to be prepared to assess other types of unintended effects as well.

iv. Assessing Sustainability

A final challenge with regard to observed changes in the core outcome/impact indicators for GAVI HSS, particularly in 2012, concerns the dimension of sustainability. Questions about the sustainability of impacts are often even more shrouded in fog than questions of attribution of changes to an intervention. Sustainability is a highly contested concept that is difficult to pin down in terms of measurable indicators or objectives. Any assessment of the sustainability of GAVI HSS investments and impacts should distinguish between different units of assessment (e.g., institutions, health systems) and different dimensions of sustainability (e.g., financial sustainability, capacity sustainability).

The monitoring and evaluation plan described below proposes approaches to address these challenges.

3. Proposed Monitoring and Evaluation plan

A. Introduction to the Monitoring and Evaluation Plan

The evaluation GAVI HSS evaluation framework takes a stepwise approach, differentiating the aims of the 2009 evaluation from those of the 2012 evaluation such that they incrementally build on each other. The 2009 evaluation focuses on the five processes to demonstrate their level of performance, interrelatedness, issues and potential solutions. These include proposal design, development and approval process; design and implementation of GAVI HSS-funded activities; management of funds; monitoring and evaluation of activities; and possible outcomes of funding support.

As such the 2009 evaluation focus is primarily on processes and experiences using a qualitative research approach to be used alongside any available quantitative data. Additionally the 2009 evaluation would include an assessment of progress against output indicators, with particular attention to determining the gaps in both data and monitoring systems that would need to be in place prior to the 2012 evaluation. The 2012 evaluation expands to include a greater emphasis on actual HSS and associated outcomes.

The proposed plan includes both monitoring and evaluation, two essential but distinct components that are often misunderstood. The following discussion of definitions provides a frame of reference to understand the proposed plan.

i. Monitoring vs. Evaluation

Monitoring answers questions about performance, and provides routine information about how the intervention is implemented and utilized, as well as its “coverage”, which managers can use to make decisions about how to improve the intervention. Evaluation aims to answer questions about whether to continue, expand, or change an intervention; the assumption is that performance of the intervention is optimal.

Evaluation requires different information than routine monitoring; otherwise the risk is that outcomes and impact become confused, and observed changes can be incorrectly attributed to a specific intervention.

While quality, useable routine data is also needed from a well-designed monitoring system to understand how the GAVI HSS funding stream is performing, GAVI HSS also needs to evaluate whether this funding window is a worthwhile investment, in terms of increased and sustained immunization coverage and contribution to the MDGs. The evaluations in 2009 and 2012 will attempt to answer both types of questions. The emphasis in 2009 will be on identifying performance problems that can potentially affect the outcomes of interest, as well as on identifying how observed impact can be best linked with GAVI HSS in 2012.

ii. Evaluability vs. Evaluation

This study assesses how ready GAVI HSS is for conducting an impact evaluation in 2009 and 2012, given the objectives and current modes of implementation and monitoring. In doing so, the evaluability study suggests a “tempered” ideal evaluation approach and set of questions, based on what questions need to be answered for GAVI, and what information is likely to be available. The factors of resources and time that will be made available for the evaluation are not considered as limiting factors in this study. In addition, this study does not prescribe specific data collection tools or indicators to be used; the selection of these will ultimately depend on the chosen approach taken by the evaluation team, which will likely be different than the team that has prepared the evaluation plan presented in this report. In the transition and translation from one team to another, it is likely that changes will be made; therefore, prescribing specifics may be premature.

B. Proposed Evaluation Approach

The 2009 evaluation should focus on answering the following key questions:

1. Has GAVI HSS operated according to its guiding principles?
2. Has GAVI HSS contributed to any observable health systems strengthening?
3. What are the strengths and weaknesses of key GAVI HSS processes?
As stated in the GAVI HSS *Investment Case*, as it will be too early to assess health impact and outcomes, the 2009 exercise should focus on establishing credible baselines where needed, and putting processes in place for impact data collection for 2012.

The three overarching questions for 2009 have been operationalized, with associated indicators and data sources, in Table 2. In answering these questions in 2009, the evaluation should also:

- Identify critical contextual factors that are likely to influence HSS interventions and immunization service coverage
- Map indicators used in the country M&E frameworks against global HSS indicator frameworks
- Identify weaknesses or gaps in the GAVI HSS monitoring system that need strengthening for 2012
- Identify additional data gaps that need to be addressed for 2012
- Identify the range of special studies that need to be designed and implemented for 2012.

In addition, the 2009 evaluation should ensure quality baseline measurements of the three core outcome/impact indicators for GAVI HSS. A major objective of the 2009 evaluation should also be to further specify the conceptual map of causality, and the associated pathways, based on the findings, which should lead to hypotheses about the effects in the three outcome/impact indicators which can be expected to be observed in 2012. Development of these hypotheses based on the evaluation in 2009 should allow for further specification and refinement of the evaluation questions and data collection activities in 2012.

In 2012, the evaluation should answer the following questions:

1. Has GAVI HSS contributed to any observable health systems strengthening?
2. Has GAVI HSS contributed to changes in immunization coverage or under-five mortality?
3. Which GAVI HSS operated guiding principles most likely affect the effectiveness of the funding?
4. What strengths and weaknesses of key GAVI HSS processes most likely affect the effectiveness of the funding?

The question of clearly attributing immunization coverage or under-five mortality changes to GAVI HSS interventions, as well as the determination of the magnitude of GAVI HSS intervention effects, is largely out of reach for any impact evaluation, both in 2009 and 2012. Given the complexity surrounding the impacts of GAVI HSS funding on immunization and child health, not to mention on any HSS effects themselves, the evaluation will be at least as much about generating insights about processes of change instigated and/or influenced by GAVI HSS interventions as about the actual demonstration of change attributable to GAVI HSS. In practice, the latter cannot be established in a reliable manner without the first.
The GAVI HSS evaluation must begin in 2009 by mapping different processes of change related to different intervention activities within the portfolio of GAVI HSS funded proposals. Then, at different levels of analysis, it may be possible to design additional, appropriate data collection and case studies to be done in 2012, to establish more clearly potential paths of attribution.

The primary challenge to starting down a path to attribution is the counterfactual problem (described above). For GAVI HSS, there are two possible solutions to the counterfactual problem. First, some countries (e.g., DRC, Kenya, Sri Lanka, Zambia) designed their HSS activities to focus on selected districts. Within these countries, it may be possible to compare immunization effects in these HSS districts with those in districts where HSS interventions were not implemented. However, it must be taken into account that often the HSS districts were selected based on their lower performance; the rate of change within HSS-intervention versus non-HSS districts, rather than the difference between the two, must be the focus of the evaluation. Additionally, the problem of “aggregation” of district-level findings to the global or country level, as discussed above, must be addressed. A second possible solution is to select comparison countries that have received GAVI, but not GAVI HSS, funding. Selection of the comparison countries must be done by matching on important background variables (e.g. pooled financing, baseline immunization coverage and any others which should be further identified through the 2009 evaluation), and time trend analysis should be used in 2012 to refine any observed differences in the outcome and impact indicators. (See Annex A for methodological recommendations.)

### C. Proposed Monitoring Approach

The objective of a monitoring system is to answer questions about how well a program or project is performing, and suggests ways in which performance can be improved. Four key evaluation questions outlined above will be informed by monitoring data collected.

The proposed approach for monitoring for the GAVI HSS funding window is consistent through 2012; the difference lies in the interpretation of the indicators for the 2009 and 2012 evaluation. Essentially, the 2009 interpretation and analysis of monitoring data will inform whether there has been increased alignment, capacity, harmonization and/or a focus on sustainability. It may also provide for the three core indicators required for GAVI HSS funding. The 2012 interpretation will measure more epidemiological and programmatic impact of GAVI HSS funding window, as well as assess whether improvements observed in 2009 have been sustained.

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**Notes:**

23 These may include funding for Immunization Services Support (ISS), Underused Vaccines Support (NVS) and Civil Society Organisation support (CSO).

24 The time lag between the implementation of household surveys and the publication of under-five mortality rates, tend to be approximately one and a half years or more in some developing countries. Thus collecting such indicators in 2009 is likely to represent a base line of 2007 – when countries received their first batch of GAVI HSS funding.
The purpose of the monitoring approach proposed below is not to identify specific country performance for follow-up or special monitoring, although such as system could also be put in place. Table 1 specifies the key GAVI HSS processes that need to be tracked. For each of these processes, a variety of indicators can be proposed. This evaluability study suggests a list of possible indicators that could be used in Table 2.

A review of the key processes and available information from the current data sources points to several general areas of weakness in the current GAVI HSS monitoring system that should be strengthened, especially in preparation for the evaluations to be conducted in 2009 and 2012. The following section describes these in detail.

**D. Data Collection Approaches**

The data sources for the 2009 and 2012 M&E plan are outlined in Table 1. As is recommended in the the operationalized evaluation framework (Annex E), data can be sourced at three levels; the country level, the global level and the portfolio of awards level. At the country level, it suggests that the evaluation team review proposals and country reports, as well as interview key individuals involved in the implementation and M&E of GAVI HSS funded activities. At the global level, it proposes an assessment of the contributions of global level bodies\(^{25}\) to both in-country processes and global level processes. An analysis at the portfolio level is recommended in order to determine the extent to which the GAVI HSS funding window fulfils the intentions outlined in the investment case, and to identify the contribution of this funding window to global HSS efforts. It is proposed that this analysis involve a review of proposals and country reports, and that it is supported up by data collected during the country studies and interviews with key GAVI HSS stakeholders at the global level.

Some of these tasks may be part of the ongoing GAVI HSS activities, such as the recently commissioned tracking study and the strengthening of the monitoring framework\(^{26}\). It is expected that the tracking study will include country case studies along with a desk and literature review. The updated monitoring system is expected to propose a more comprehensive Annual Progress Report, as well as differentiated approach to monitoring countries receiving GAVI HSS support.

A first step of the 2009 evaluation should be to determine the progress and content of the tracking study and expanded monitoring systems and decide which activities can utilize existing data or studies, and which needs to be added as part of the 2009 evaluation work. In addition, depending on the timing of these activities, there may be important opportunities for coordination, so that the tracking studies and the expansion of the routine monitoring system can feed into the evaluations in 2009 and/or 2012.

\(^{25}\) These would include the GAVI HSS Secretariat, the GAVI Alliance Task Team, the Board, the Independent Review Committee and partners

\(^{26}\) As outlined in Annex 2 of the GAVI Alliance & Fund Board meeting Minutes (25 & 26 June 2008)
### Table 1: Monitoring and Evaluation Data Sources

<table>
<thead>
<tr>
<th>Level</th>
<th>Monitoring</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country</strong></td>
<td>• Systematic tracking of health system indicators</td>
<td>• Household or Community Surveys</td>
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<tr>
<td></td>
<td>• Household or Community Surveys</td>
<td>• Country Studies: Country Progress Assessments</td>
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<tr>
<td></td>
<td>• Country Studies: Country Progress Assessments</td>
<td>• Studies for specific data needs</td>
</tr>
<tr>
<td></td>
<td>• Studies for specific data needs</td>
<td></td>
</tr>
<tr>
<td><strong>Global</strong></td>
<td>• Systematic tracking of proposal approvals and quality</td>
<td>• Analysis of monitoring information</td>
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<tr>
<td></td>
<td>• Systematic tracking of financial information</td>
<td>• Desk and Literature Review</td>
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<tr>
<td></td>
<td></td>
<td>• Key Opinion Leader and Stakeholder interviews</td>
</tr>
<tr>
<td><strong>Portfolio</strong></td>
<td>• Systematic tracking of country identified indicators, progress on work plan</td>
<td>• Analysis of HSS grant information</td>
</tr>
</tbody>
</table>

### i. Monitoring

The recent review of the HSS proposals suggests additional information that would be useful for monitoring. This evaluability assessment recommends that the following areas be strengthened for routine monitoring at the GAVI HSS Secretariat level.

1. **Systematic tracking of proposal approvals and quality**

GAVI HSS needs to establish a database that incorporates components included in the proposal, partners involved in the proposal development process, key Independent Review Committee (IRC) comments on the proposal, and the result of the IRC review, and Board decision. This information would allow tracking of approval rates and quality of the proposals to more clearly show GAVI where investments need to be made to strengthen proposals. For example, recent reviews of the 29 HSS proposals funded to date show that IRC review could be facilitated by such a standard database. A large number of proposals together were missing key components of M&E, or entire frameworks. A checklist for IRC use in proposal review could then be derived from the monitoring data. As GAVI HSS considers its continuation and expansion, these systems need to be in place in order to readily provide information to the GAVI Alliance Board.

2. **Systematic tracking of financial information**

Without putting too much burden on the countries, GAVI HSS should track the rate of its funds disbursements, so that it can adjust its own internal processes to ensure maximum efficiency in financing. For example, the time from approval to first disbursement should be part of the database, as

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27 Assessment of the Quality of the Results Frameworks of GAVI HSS Proposals, 22 Feb 2008; HSS Proposals: Good example document; draft for comment 10 June 2008.
28 Ibid.
well as subsequent disbursements, to allow for monitoring or any undue delays. Rates of program implementation can also then be monitored to assess overall performance of the HSS activities at the portfolio level. The purpose is not to flag individual countries for “delayed implementation”, although the information could be used to that end. Without basic financial information available at the portfolio level, it is difficult to comment on the relative efficiency of GAVI HSS as a funding mechanism.

3. Core indicators
GAVI HSS should consider tracking at least the core outcome indicator of immunization coverage across all funded proposals. This would mean requiring country proposals to include this indicator in the M&E framework. Currently not included in 5-8 country proposals. This is a fairly routine programmatic and health indicator, and should be readily available for all countries, although the quality of the data may be in question in some cases. As sustained immunization coverage is the objective of GAVI HSS funding, any monitoring system should include this indicator.

4. Health systems indicators
The country annual progress reports provide information on the indicators and progress against targets that are specific to that country’s proposal. However, GAVI HSS should consider some more “aggregate” indicators that group discrete country activities and interventions into the three health systems areas that are highlighted in the guidelines. Further work needs to be done to identify how this can best be done. The issues of service quality and equity will likely only be addressed through periodic special studies and evaluations.

Implicit in these changes and improvements to a GAVI-level monitoring system is that changes must be made at the country level, where the data will be generated, which in turn implies that revisions to the guidelines and the annual progress report format will need to be made. This evaluability study recommends that at minimum, countries should routinely report on expenditures and immunization coverage rates. In addition, countries should be encouraged to report, in a standard format, the partners who participate in proposal development, and remain involved in GAVI HSS intervention implementation and coordination. GAVI should make clear that HSS proposals are required to include M&E frameworks, immunization coverage as an indicator, and a categorization of interventions into the three health systems areas before they will be considered for funding; a checklist for these, and a routine monitoring database will assist countries, GAVI HSS, and the IRC in ensuring minimum requirements for useful performance monitoring are being met.

ii. Evaluation
A combination of five complementary approaches is proposed to address the above evaluation questions. These approaches include;

29 Assessment of the Quality of the Results Frameworks of GAVI HSS Proposals, 22 Feb 2008.
30 Namely, health workforce, drugs and commodities, and management of health services.
1. Key Opinion Leader and Stakeholder interviews
2. Desk and Literature Review
3. Analysis of HSS grant information
4. Country Studies: Country Progress Assessments (CPAs)
5. Household or Community Surveys

In addition to these five evaluation approaches, certain studies specific to country data needs may be suggested by the evaluation team.

1. **Key Opinion Leader and Stakeholder interviews**
A key component of the evaluation should involve interviews with a series of stakeholders from global level governing bodies. This approach has two key purposes; first, it facilitates a clear understanding of the context, environment, history, and priorities of GAVI HSS that is critical to the implementation of a meaningful, engaged, usable evaluation; second, it provides global level opinions on the strengths and weaknesses of key GAVI HSS processes, whether GAVI HSS has operated according to its guiding principles, and whether it has contributed to any observable health systems strengthening. It also allows for the identification of unintended effects as well as priority needs to support the 2012 evaluation.

To address the overarching evaluation questions, a semi-structured open-ended interview approach is recommended. The interview tools should be designed to capture information on various components of the GAVI HSS finding window, including the provision of technical assistance to countries, proposal and annual progress report review processes, funding flow to the countries, M&E processes, and the perceived and measured outcome/impact of GAVI HSS to global HSS. The tools should also consider the expertise and experience of the respondents. Stakeholders at the global level may include representatives from partner organizations, global civil society organizations, the GAVI Secretariat, the GAVI Alliance Task Team, the GAVI Alliance Board, and the GAVI HSS IRC.

2. **Desk and Literature review**
Several reports addressing the impact and outcomes of GAVI HSS have been completed, commissioned or published (e.g. the WHO analysis of GAVI Proposals, or the analysis of the M&E plans in GAVI HSS proposals). To exploit existing resources, and to avoid the duplication of work, a thorough literature review of existing reports, evaluations, and analyses on both GAVI HSS, as well as broader HSS initiatives is recommended.

The desk review will address all overarching evaluation questions and is expected to enhance the analysis of monitoring information, as well as inform the development of KOL interview and Country Progress Assessment (CPA) tools (described below). The proposed approach involves a

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31 See footnote 20
consolidation, organization and review of documentation on both GAVI HSS and HSS generally, by evaluation questions.

3. **Analysis of HSS grant information**
Grant information may include individual country proposals, IRC review notes and comments, Annual Progress Reports and any additional routine monitoring information. Analysis of this information should offer a synthesized and comprehensive perspective on progress achieved, as well as concrete recommendations to improve the design of the components of the GAVI HSS initiative.

Albeit that the M&E plan proposes that similar information is collected in 2009 and 2012, analysis and interpretation of monitoring data should be distinct. The 2009 interpretation should indicate whether interventions addressed the bottlenecks that they set out to address, and whether they have been addressed according to established principles. The 2012 interpretation should examine whether improvements in bottlenecks have contributed to health impacts and outcomes. The latter will provide evidence that there has been a health impact from addressing health systems bottleneck, where as the former will assess whether the improvements in bottleneck are evident.

The evaluation team should use the time trend analysis of compiled the monitoring information, complemented with additional evaluation information to address the evaluation questions outlined above.

4. **Country Studies: Country Progress Assessments (CPA)**
Given the short period between the receipt of funding and the 2009 evaluation, complemented with the challenges of attribution of HSS initiatives, a qualitative and participatory approach to country studies is proposed. To capture progress towards intended GAVI HSS impact and outcomes it is essential to engage key HSS and immunization stakeholders.

CPAs should address all overarching evaluation questions – including stakeholder’s opinions as to whether GAVI HSS has operated according to its established principles, whether it has contributed to HSS, health impacts and outcomes.

CPAs are in-depth assessments which should be carried out in approximately four countries receiving GAVI HSS funding, two GAVI eligible countries not receiving HSS funding (See Annex A for proposed approach for country selection). Evaluators may also chose to address the counterfactual challenge by implementing a CPA approach in districts not benefiting from GAVI HSS funding. CPA’s should be conducted by a team of 3-5 researchers over the period of 2-3 weeks. These teams should use a semi-structured open-ended interview approach with partners and stakeholders to collect information on the GAVI HSS initiative in-country.

CPA modules should be designed to capture information regarding various in-country components of the GAVI HSS finding window. These components include the proposal design processes, funding flow (within countries), the receipt of technical assistance, in country decision making processes and
Each module should consider the experience and expertise of the respondents. Respondents at the country level may include stakeholders in the Ministry of Planning, Health and Finance, as well as in partner organizations, civil society organizations and donor organizations. Within each module, information collected should be both of qualitative and quantitative nature, according to indicators and metrics suggested outlined in Table 2.

5. Household or Community Surveys
Approximately 10 of the 29 country proposals do not include the three required core outcome indicators in their monitoring framework. To evaluate the impact of GAVI HSS to health impacts and outcomes it is essential that all countries receiving funding are able to produce both a baseline and an indication of progress in 2012. In addition to the countries receiving funding, countries or districts serving as counterfactuals should also be able to produce these figures. Without putting too much additional reporting burden on the countries, the evaluators may need to commission household level surveys to determine the 2012 immunization coverage and under-five mortality in all countries.

Household level surveys are expected to address whether GAVI HSS has contributed to the increase in immunization coverage, and whether there has been an impact on health, as measured through DPT3 coverage, number (%) of districts achieving >80% DPT3 coverage, under-five mortality rates.

Countries may already have systems in place to determine immunization coverage and health impacts by 2012. For those countries without systems in place, a household level survey may be commissioned to provide the three core indicators.

6. Additional studies
Specific to country data needs may be suggested by evaluators in order to complete information necessary to complete an evaluation. These may include demographic and health surveys (DHS), cluster studies, EPI program data analysis, or national health accounts.

These approaches will not work independently from each other; rather they should complement each other. For example, qualitative feedback on quality of service delivery may inform progress and challenges in DPT3 coverage.

32 Assessment of the Quality of the Results Frameworks of GAVI HSS Proposals, 22 Feb 2008.
<table>
<thead>
<tr>
<th>Evaluation Question 1: Has GAVI HSS operated according to its established principles?</th>
<th>Operationalized Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Data Sources 2009</th>
<th>Indicators 2012</th>
<th>Data Sources 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Has GAVI HSS been country-driven?</td>
<td>Revisions to documentation/analysis of bottlenecks in proposal Progress on activity-specific monitoring indicators (for Round 1 countries only)</td>
<td>Analysis of HSS Grant Information Country studies</td>
<td></td>
<td>Identification of new or additional bottlenecks Changes made to or new activities added % of funding used for new or changed activities Progress on activity-specific monitoring indicators (more countries than 2009)</td>
<td>Analysis of HSS Grant Information Country studies</td>
<td>Key issue – are the activity changes evidence-based?</td>
</tr>
<tr>
<td>1.2 Has GAVI HSS been country-aligned?</td>
<td>GAVI disbursement cycles v. national fiscal cycles GAVI reporting requirements v. national reporting cycles Comparison of GAVI financial management requirements to national auditing processes – cycles, standards and quality, reporting Perceived additional burden of GAVI financial management v. other HSS streams % of GAVI HSS funding windows that are aligned with national fiscal cycles</td>
<td>Country studies</td>
<td></td>
<td>Time trends in: Comparison of GAVI financial management requirements to national Perceived additional burden of GAVI financial management v. other HSS streams % of GAVI HSS funded countries that are aligned with national fiscal cycles</td>
<td>Country Studies</td>
<td></td>
</tr>
<tr>
<td>1.3 Has GAVI HSS been harmonized?</td>
<td>GAVI reporting requirements v. other HSS funding stream requirements Role of national coordination committees in reporting, management and achieving harmonized financial management requirements</td>
<td>Country studies</td>
<td></td>
<td>Time trends in: GAVI reporting requirements v. other HSS funding stream requirements Role of national coordination committees in reporting, management and achieving harmonized financial management requirements</td>
<td>Country Studies</td>
<td></td>
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<tr>
<td>Operationalized Evaluation Questions</td>
<td>Indicators 2009</td>
<td>Data Sources 2009</td>
<td>Indicators 2012</td>
<td>Data Sources 2012</td>
<td>Comments</td>
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</table>
| 1.4 Has GAVI HSS been predictable?  | Average length of time between disbursements  
Stakeholder perspectives | Country Studies | Time trends in:  
Disbursement flow rates | Country Studies | While additionality and fungibility of funds is often of great interest, their measurement is challenging and often not feasible – planning is needed if either is to be assessed in 2012 |
| 1.5 Has GAVI HSS been additional?  | GAVI HSS funds as a proportion of overall HSS budget  
Number of other HSS funding streams  
Map of contribution of GAVI HSS funds and activities to national HSS strategy (where possible)  
Perceived advantages and disadvantages of GAVI HSS funding, compared to other funding streams | Country studies  
KOL and SH Interviews (HSS partners)  
NHA data | Time trends in:  
GAVI HSS funds as a proportion of overall HSS budget  
Number of other HSS funding streams  
Map of contribution of GAVI HSS funds and activities to national HSS strategy (where possible)  
Qualitative assessment of GAVI HSS v. other HSS funding streams  
Additionality of GAVI HSS funds | Country Studies  
KOL and SH Interviews (HSS partners)  
NHA data | |
| 1.6 Has GAVI HSS been inclusive and collaborative?  | Map of partner roles in proposal steps  
Roles played by national coordination committees  
How many partners are involved in the implementation  
What % of original partners are involved post implementation?  
What % of implementation partners were not part of original proposal? | Country studies | Time trends in partner roles for proposal development  
% key stakeholders centrally involved in proposal development process still playing a role in HSS or immunization | Country studies | Diminishing partner roles may indicate increasing country capacity, not decreased coordination |
| 1.7 Has GAVI HSS been catalytic?  | % awards where GAVI HSS efforts were expanded to other areas in-country  
Stakeholder perspectives | Country Studies | Time trends in % awards where GAVI HSS efforts were expanded to other areas in-country | Country Studies | |
| 1.8 Has GAVI HSS been results-oriented?  | % countries with M&E frameworks functional  
% monitoring all three core indicators | Analysis of HSS Grant Information  
Country Studies | Trends in % countries with M&E frameworks functional  
Trends in % monitoring all three core indicators | Analysis of HSS Grant Information  
Country Studies | |
| 1.9 Has GAVI HSS been sustainability conscious?  | % awards with a sustainability plan for maintaining achievements after the funding window ends  
Stakeholder assessments of principal challenges and opportunities for sustainability | Analysis of HSS Grant Information  
Country studies | Trends in % awards with a sustainability plan for maintaining achievements after the funding window ends  
Stakeholder assessments | Analysis of HSS Grant Information  
Country studies | |
Evaluation Question 2: Has GAVI HSS contributed to strengthening health systems?

<table>
<thead>
<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Data sources 2009</th>
<th>Indicators 2012</th>
<th>Data Sources 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Has GAVI HSS contributed to increased access to primary health services?</td>
<td>Design of activities funded by GAVI HSS, relative to other HSS activities in country</td>
<td>Country studies</td>
<td>Changes in utilization rates of services, by district, related to the proportion of overall GAVI HSS funding at central level</td>
<td>Country studies</td>
<td>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</td>
</tr>
<tr>
<td>2.2 Has GAVI HSS contributed to greater equity in immunization coverage?</td>
<td>Identification of marginalized groups, areas in proposal Assessment of capacity to measure equity changes Plan in place for assessing baseline equity in immunization coverage Baseline measure</td>
<td>Country studies</td>
<td>Changes in immunization coverage among marginalized groups v. non-marginalized Perceived changes from marginalized group perspective</td>
<td>Country studies</td>
<td>May be difficult to measure equity early enough to find changes by 2012. This could present an opportunity for a participatory approach to capacity-building</td>
</tr>
<tr>
<td>2.3 Has GAVI HSS contributed to greater quality in service delivery?</td>
<td>% of activities that target service quality improvement funded by GAVI HSS</td>
<td>Country studies</td>
<td>Changes in service quality, related to the proposal of funding dedicated to service quality activities in GAVI HSS funding and overall</td>
<td>Country studies</td>
<td>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</td>
</tr>
<tr>
<td>2.4 Has GAVI HSS contributed to greater efficiency in service delivery?</td>
<td>Cost per service unit (per immunization, or full set of immunization) – establish baseline</td>
<td>Country studies</td>
<td>Cost per service unit (per immunization, or full set of immunizations)</td>
<td>Country studies</td>
<td>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</td>
</tr>
<tr>
<td>2.5 Has GAVI HSS contributed to greater donor coordination and participation?</td>
<td># of in-country donors who use the GAVI HSS proposal as reference/planning tool Participation of donor partners in proposal development and implementation Perceived impact of GAVI HSS on donor coordination</td>
<td>Country studies</td>
<td># of in-country donors who use the GAVI HSS proposal as reference/planning tool Participation of donor partners in implementation and technical support Perceived impact of GAVI HSS on donor coordination</td>
<td>Country studies</td>
<td>At the global level, GAVI participation and leadership in HSS initiatives should also be linked</td>
</tr>
</tbody>
</table>
### Evaluation Question 3: Has GAVI HSS contributed to health impacts?

<table>
<thead>
<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Data Sources 2009</th>
<th>Indicators 2012</th>
<th>Data Sources 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Has GAVI HSS contributed to greater immunization coverage?</td>
<td>DTP3 rate (national)</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td>Trends in DPT3 rate (national)</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td></td>
</tr>
<tr>
<td>3.2 Has GAVI HSS contributed to improved geographic equity in immunization services?</td>
<td>% districts with ≥ 80% immunization coverage</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td>Trends in % districts with ≥ 80% immunization coverage</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td></td>
</tr>
<tr>
<td>3.3 Has GAVI HSS contributed to declines in under 5 mortality?</td>
<td>Under 5 mortality rate</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td>Trends in Under 5 mortality rate</td>
<td>National health assessments, EPI program data, Community-based surveys, DHS</td>
<td></td>
</tr>
</tbody>
</table>

When feasible, in-country data sources and information presented in proposals will be used to ascertain these impact baselines/ indicators, however at least 10 of 29 countries are not collecting at least one core indicator to date; in such cases alternative data collection methods will be used to establish indicator.

---

Pioneering Healthcare Solutions in the Developing World
## Evaluation Question 4: What are the strengths and weaknesses of key GAVI HSS processes?

<table>
<thead>
<tr>
<th>GAVI HSS Processes</th>
<th>Indicators 2009</th>
<th>Data Sources 2009</th>
<th>Indicators 2012</th>
<th>Data Sources 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Proposal development and submission</td>
<td>Approval rates by round&lt;br&gt;Re-application rates; # countries applying more than twice&lt;br&gt;% of applicants receiving proposal TA&lt;br&gt;Adequate targeting of activities to bottlenecks&lt;br&gt;Gap analysis in proposal&lt;br&gt;Cost estimation process&lt;br&gt;Relevance to national HSS strategies (where relevant)&lt;br&gt;Role played by external TA v. country partners&lt;br&gt;Perceived capacity building contribution of TA</td>
<td>KOL and SH Interviews (GAVI Secretariat; IRC)&lt;br&gt;Analysis of HSS Grant Information</td>
<td>Time trends in approval rates&lt;br&gt;% of applicants receiving proposal TA&lt;br&gt;Sources of proposal TA&lt;br&gt;Approval rates of TA-supported proposals v. non-TA supported proposals&lt;br&gt;Role played by external TA v. country partners</td>
<td>KOL and SH Interviews (GAVI Secretariat; IRC)&lt;br&gt;Analysis of HSS Grant Information</td>
<td>Much of the data on proposal and approval rates exist at the Secretariat, but is not organized for systematic monitoring</td>
</tr>
<tr>
<td>4.2 Program implementation</td>
<td>Expenditure rates&lt;br&gt;Adherence to workplans&lt;br&gt;Documentation of changes to workplans&lt;br&gt;How many partners are involved in the implementation</td>
<td>Analysis of HSS Grant Information Country studies</td>
<td>Expenditure rates&lt;br&gt;Adherence to workplans&lt;br&gt;How many partners are involved in the implementation&lt;br&gt;What % of original partners are still involved in implementation?&lt;br&gt;Reasons for drop out&lt;br&gt;What % of implementation partners were not part of original proposal?</td>
<td>Analysis of HSS Grant Information Country Studies</td>
<td></td>
</tr>
<tr>
<td>GAVI HSS Processes</td>
<td>Indicators 2009</td>
<td>Data Sources 2009</td>
<td>Indicators 2012</td>
<td>Data Sources 2012</td>
<td>Comments</td>
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<tr>
<td>4.3 In-country management of funds</td>
<td>% approved proposals that identify the responsible fund manager/recipient GAVI HSS funds maintained and managed separately, or integrated into a larger budget – which budget? Disbursement rates of GAVI v. other HSS funds Processes for disbursing funds to districts Disbursement delays to implementation/district levels Map of GAVI HSS fund flow in countries (compare to other HSS funding streams) Procurement tender processes – who, how; integration with national standards Auditing processes – national standards v. GAVI requirements Assessment of potential for funds misuse</td>
<td>Country studies KOL and SH Interviews (HSS partners)</td>
<td>Time trends in: % approved proposal that identify the responsible fund manager/recipient GAVI HSS funds maintained and managed separately, or integrated into overall budget Budgets into which GAVI HSS funds are integrated Disbursement rates of GAVI v. other HSS funds Disbursement delays to implementation/district levels Map of GAVI HSS fund flow in countries (compared to other HSS funding streams) Changes in procurement tender processes – who, how; integration with national standards Auditing processes – national standards v. GAVI requirements Assessment of evidence that indicates potential funds misuse</td>
<td>Country studies KOL and SH Interviews (HSS partners)</td>
<td>Working with other HSS partners to allow easy collection of comprehensive data on HSS funding will be a key objective for 2012</td>
</tr>
<tr>
<td>4.4 In-country monitoring and evaluation systems</td>
<td>Lead M&amp;E organization identified in the proposal - reasons for selection Changes made in M&amp;E leads during implementation – reasons Logical links between process, output, and outcome indicators # of indicators per activity At least one output per activity captured Gaps in capturing performance % GAVI HSS indicators that are part of existing in-country data collection/reporting systems % of GAVI HSS indicators that are used for M&amp;E reports to other HSS funders Of the common indicators, % that use the same definition Evaluation plan in proposal Evaluation plan developed after proposal</td>
<td>Analysis of HSS Grant Information Country studies</td>
<td>Changes made in M&amp;E leads during implementation - reasons # of indicators per activity At least one output per activity captured Core indicators Time trends in: % GAVI HSS indicators that are part of existing in-country data collection/reporting systems % of GAVI HSS indicators that are used for M&amp;E reports to other HSS funders Of the common indicators, % that use the same definition # of country-level evaluations of GAVI HSS conducted # operations research studies conducted</td>
<td>Country studies KOL and SH Interviews (HSS partners)</td>
<td></td>
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<tr>
<td>GAVI HSS Processes</td>
<td>Indicators 2009</td>
<td>Data Sources 2009</td>
<td>Indicators 2012</td>
<td>Data Sources 2012</td>
<td>Comments</td>
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<tr>
<td>4.5 Proposal review</td>
<td>HSS expertise representation on IRCs, by round Time between application, review, and notification to countries Documentation of review process Monitoring systems for proposal review process Information availability to applicants and others re, proposal review comments/recommendations Country satisfaction with review and communications from GAVI</td>
<td>KOL and SH Interviews (GAVI Secretariat; IRC members) Analysis of HSS Grant Information</td>
<td>Documentation of review process Monitoring systems for proposal review process Information availability Time trends in country satisfaction with GAVI communications and review process</td>
<td>KOL and SH Interviews (GAVI Secretariat; IRC members) Analysis of HSS Grant Information</td>
<td>GAVI HSS IRC may consider developing a standard report format for each review process, to allow monitoring over time</td>
</tr>
<tr>
<td>4.6 TA services implementation</td>
<td>% countries requesting and receiving TA for implementation # of implementation TA requests and receipts, per country Identification of common implementation TA needs Partners roles in facilitating access to TA</td>
<td>Country studies KOL and SH Interviews (Partners)</td>
<td>% countries requesting and receiving TA for implementation # of implementation TA requests and receipts, per country Partners roles in facilitating access to TA</td>
<td>Country studies KOL and SH Interviews (Partners)</td>
<td></td>
</tr>
<tr>
<td>4.7 Efficiency of disbursement of funds</td>
<td>Average time from proposal approval to first disbursement Average subsequent disbursement time % of disbursement requests that can considered “delayed”</td>
<td>KOL and SH Interviews (GAVI Secretariat) Country studies</td>
<td>Time trends in average disbursement time and delays</td>
<td>KOL and SH Interviews (GAVI Secretariat) Country studies</td>
<td>GAVI Secretariat needs to develop more systems to allow for regular monitoring</td>
</tr>
<tr>
<td>4.8 Global M&amp;E Systems</td>
<td>Data collection systems in place for all “new” HSS indicators Quality assurance processes in place for all GAVI HSS M&amp;E data Geographic coverage of GAVI HSS M&amp;E reporting</td>
<td>Country studies Analysis of HSS Grant Information</td>
<td>Time trends in: Data collection systems in place for all HSS indicators Quality assurance processes in place for all M&amp;E data Geographic coverage of M&amp;E reporting</td>
<td>Country studies Analysis of HSS Grant Information</td>
<td>Assessment must be linked with capacity of lead M&amp;E organization and partners</td>
</tr>
</tbody>
</table>
4. Key Recommendations

1. GAVI must strengthen the routine monitoring of its HSS funding window, both to support the evaluations in 2009 and 2012, but also to improve its own operations. The following data should be included in routine GAVI HSS monitoring:
   - Systematic tracking of proposal approvals and quality
   - Systematic tracking of financial information, in particular disbursement and expenditures rates
   - All three core outcome and impact indicators, for each GAVI HSS-funded country
   - Key HSS indicators, defined by the three health systems areas suggested by the GAVI HSS guidelines

   Detailed discussion of the monitoring data needs is presented in section 3.C of the report.

2. GAVI should develop the evaluation RFP and budgets to include comparison countries as “counterfactuals” – countries that have received GAVI ISS, but not HSS, funding. The comparison countries should be matched on:
   - Baseline immunization coverage
   - HSS capacity (as measured by HWs per 1000)
   - ISS $ per capita
   - Population size

   More detailed discussions of the counterfactual issues are presented in sections 2.D and 3.C.

3. GAVI should ensure that countries prepare for the measurement of impact in 2009 (baseline) and 2012. In addition, GAVI should consider ensuring that impact is measured in 2015, to assess progress against the MDGs in GAVI HSS-funded countries. Preparation for impact measurement in the HSS and comparison countries should include:
   - Assessment of the quality and timeliness of existing baselines
   - Identification of planned country data collection activities that could include immunization coverage or under-five mortality assessment (e.g., planned DHS)
   - Identification of in-country institutions and capacity for conducting an impact assessment
   - Identification of appropriate external capacity and support for each country

   Data collection needs for impact evaluation are discussed in section 3.D.
Annexes

Annex A: Country Selection Recommendations

Country selection has two objectives. First, to select a set of countries receiving GAVI HSS funding that represent a wide range of experiences with GAVI HSS funding window. Second, to select a set of counterfactual countries (2 GAVI eligible countries not receiving HSS funding, and 2 countries receiving no GAVI funding).

Methodology: The Borda ranking procedure is recommended, as it “allows the aggregation of indicators with different units of measurement and different periods and country coverages; that is, it allows comparisons among countries across categories even when the number of countries studied varies by category”34. It involves assigning each country a value equal to its rank in each category outlined below. The country’s points over all the components are averaged, and then used to re-rank the countries.

To select countries for a CPA, all countries receiving GAVI HSS funding should ranked using Borda ranking techniques, and subsequently divided into quartiles. From each quartile, one country should be selected for a CPA. Selection from each quartile should include at least one country with a joint or pooled financing arrangement (including IHP countries).

To identify the counterfactual countries, those countries receiving GAVI funding (excluding HSS) should be ranked and divided into halves. One country from each half should be selected as a counterfactual. This same approach should be taken for low and middle income countries (as defined by the World Bank) who are not receiving any GAVI alliance funding.

Suggested criteria for the evaluation team:

- **Experience with GAVI HSS funding**: ranked by date of receiving the first round of funding
- **Data availabilities**: ranked by availability of a baseline for all three core indicators, and a capacity to track the three core indicators
- **M&E framework**: ranked by the inclusion of the three core indicators in the proposal (baseline) and M&E framework (tracking). (For example, for each core indicator included in the M&E framework, evaluators could allocate 10 points to the country, then sum all points to arrive at a final country ranking)
- **Health system capacity related to GAVI HSS**: ranked by a composite index of the three core indicators
- **Economic status**: Fragile states, poorest group, intermediate group, least poor countries as ranked by GAVI
- **Extent of additional HSS funding**: ranked by the extent of additional HSS funding that the country received.

Annex B: Suggested Terms of Reference

TERMS OF REFERENCE FOR
GAVI HHS EVALUATION (2009, 2012)

1. BACKGROUND

- The GAVI Alliance is a unique, public and private partnership with the single and shared focus to improve child health in the poorest countries by extending the reach and quality of immunisation coverage within strengthened health services
- The GAVI Health System Strengthening (HSS) funding window was established in 2005 to achieve and sustain increased immunization coverage in all GAVI eligible countries through the strengthening of the capacity for the health system to provide immunization and other health services
- In contrast to traditional vertical health funding, the HSS window provides horizontal, innovative, flexible and predictable long-term financing
- The evaluation will need to take into account:
  - Related studies and reports commissioned by the GAVI Alliance members, and its board (e.g. tracking study, several reports)
  - The multi-stakeholder dimension of the GAVI Alliance, hence the need for broad stakeholder involvement and participation
  - The partnership and “added-value” dimension of the GAVI Alliance and the GAVI HSS funding window
- It will also need to consider the following methodological challenges:
  - Mapping causality
  - Attribution to GAVI HSS
  - Establishing an appropriate counterfactual

2. EVALUATION OBJECTIVES

The evaluation will serve different objectives:
- Gauge whether GAVI HSS has operated according to its established principles
- Assess GAVI HSS contributed to strengthening health systems
- Examine whether GAVI HSS has contributed to health impacts
- Identify and learn from strengths and weaknesses of key GAVI HSS processes
- The 2009 evaluation will provide recommendations for strengthening GAVI HSS’ monitoring and evaluation system for 2012

The 2009 evaluation should focus on answering the following key questions:
1. Has GAVI HSS operated according to its guiding principles?
2. Has GAVI HSS contributed to any observable health systems strengthening?
3. What are the strengths and weaknesses of key GAVI HSS processes?

These three overarching questions have been operationalized, with associated indicators and data sources, in the annex. In answering these questions in 2009, the evaluation should also:
- Identify critical contextual factors that are likely to influence HSS interventions and immunization service coverage
- Map indicators used in the country M&E frameworks against global HSS indicator frameworks
- Identify weaknesses or gaps in the GAVI HSS monitoring system that need strengthening for 2012
Identify additional data gaps that need to be addressed for 2012
Identify the range of special studies that need to be designed and implemented for 2012

In addition, the 2009 evaluation will ensure quality baseline measurements of the three core outcome/impact indicators for GAVI HSS. A major objective of the 2009 evaluation will also be to further specify the conceptual map of causality, and the associated pathways, based on the findings, which should lead to hypotheses about the effects in the three outcome/impact indicators which can be expected to be observed in 2012. Development of these hypotheses based on the evaluation in 2009 will allow for further specification and refinement of the evaluation questions and data collection activities in 2012.

In 2012, the evaluation should answer the following questions:

1. Has GAVI HSS contributed to any observable health systems strengthening?
2. Has GAVI HSS contributed to changes in immunization coverage or under-five mortality?
3. Which GAVI HSS operated guiding principles most likely affect the effectiveness of the funding?
4. What strengths and weaknesses of key GAVI HSS processes most likely affect the effectiveness of the funding?

These objectives will be addressed through the analysis of monitoring data and evaluation activities suggested below, and outlined in the annex.

Further amendments to the specific objectives and evaluation questions will take place during the pre-study phase through an interactive process organized by the contracted consultants in the evaluation pre-study phase.

3. SCOPE OF EVALUATION

The scope of the evaluation will evaluate the outcome and impact of the GAVI HSS funding window at both the country and global level.

Possible dimensions of the GAVI HSS funding window to be measured in the evaluation include:

- proposal design processes
- financial flows (both to the countries and within countries)
- provision of technical assistance
- global level decision making processes (i.e. review of proposals and annual progress reports)
- proposal implementation
- in-country M&E processes
- perceived and measured outcome/impact of HSS activities
- impact and outcome of these activities

4. EVALUATION PROCESS

I. Pre-study Phase

In the pre-study phase, evaluators should perform a readiness assessment of the GAVI HSS monitoring and evaluation system. Key tasks would involve:

- taking stock of the current monitoring system, as well as data availabilities (i.e. baseline data)
- identifying ongoing and exiting studies for the different dimensions of the evaluation (e.g. Tracking study, internal reports completed by partner organisations, or commissioned by the GAVI secretariat)
- prioritizing the gaps of information and considering immediate decision on filling or addressing these gaps
The pre-study report must be approved by the GAVI Board before the evaluation proceeds to the next phase.

II. Evaluation research phase

In the evaluation phase, evaluators will address the key evaluation questions through a variety of methods, these may include:

- Household or Community Surveys
- Country Progress Assessments (CPAs)
- Studies for specific data needs
- Analysis of monitoring information
- Literature Review

III. Reporting and dissemination

The steering committee will examine the evaluators draft report against the contracted criteria, and make sure that key stakeholders are invited to respond to the draft report. The steering committee will disseminate the results of the evaluation to all interested parties, in particular country stakeholders.

Expected products following each evaluation include:

- Country reports
- Global data sets
- A synthesis report
- Specific to the 2009 evaluation is a report outlining recommendations report for the 2012 evaluation should be provided.

IV. Management Response:

The GAVI board and/or the GAVI Secretariat will revise the evaluation report and recommendations and if required suggests actions to adjust the GAVI approach to HSS.

5. METHODOLOGY

The methodology should be further developed by the evaluation team during the pre-study phase, but shall at the minimum consider the following:

In terms of monitoring data, evaluators will aggregate information on the:

- proposal approvals and quality
- financial information
- three core indicators
- systematic tracking of health systems indicators

In terms of the evaluation, a combination of four complementary approaches will address the proposed evaluation questions. These include:

- Analysis of HSS grant information: such as individual country proposals, IRC review notes and comments, and Annual Progress Reports (APRs), including routine monitoring information

35 The GAVI secretariat has commissioned several reports related.
36 (1) National DTP3 coverage (%) (2) Number / % of districts achieving ≥80% DTP3 coverage and (3) U5MR
- Country Progress Assessments (CPAs) in approximately 4 countries receiving GAVI HSS funding, 2-3 GAVI eligible countries not receiving HSS funding
- Household or Community Surveys
- Desk Review

In addition to these four evaluation approaches, certain studies specific to country data needs may be suggested by the evaluators.

The establishment of an GAVI HSS Evaluation Steering Committee composed of
  - a sub-set of the Board
  - a group of additional external evaluation experts (e.g. from academia or institutions involved in the field of evaluation)

6. SKILLS REQUIRED

The evaluators are expected to have the following skills and expertise:
  - strong practical experience and skills in
    - evaluation methodology (including participatory approaches)
    - statistical analysis
    - health system research skills
    - epidemiology
    - working in developing countries
  - independence and objectivity

7. TIMELINE

August 2008 : Receipt of bids
September 2008: The evaluator is selected
October 2008 – January 2009: Pre-study phase
March – August 2009: Evaluation research phase
September 2009: 2009 evaluation research phase presented to the board
By October 2009: Evaluation report finalized
April – July 2012: Evaluation research phase
August 2012: 2012 evaluation research phase presented to the board
By September 2012: Evaluation report finalized
Annex C: Desk Review, Key Opinion Leader and Stakeholder Interviews (Deliverable 1)

Annex D: Evaluation Framework and Questions (Deliverable 2)

Annex E: Operationalizing the Evaluation Framework (Deliverable 3)
Consultancy Services for Conducting a Monitoring and Evaluability Study for GAVI’s Health System Support to Countries

Inception Report

February 2008

Axios International
Paris, France

Macro International
Calverton, Maryland
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Annex A: Desk Review Report
Annex B: Key Opinion Leader (KOL) Report

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1. Study Background

This inception report presents the methodology and preliminary findings commissioned by the GAVI Alliance to conduct an Evaluability Assessment for GAVI’s health system strengthening (HSS) funding window.

In 2004, the GAVI workplan included a study of System Wide Barriers to increase immunization coverage. This study concluded that all the countries visited had health systems issues which constrained immunization coverage – but the particular issues were different in each country. In December 2005, the GAVI Alliance Board decided that a share of future GAVI Fund resources would be devoted to investing in health system strengthening (Health System Support Window). The GAVI Alliance Board opened a $500 million budget envelope for HSS support through 2010. Since the HSS window has opened, 40 of the 72 GAVI eligible countries (55%) have applied for HSS support, and 30 (40%) have been since 2005. The Board requested that the budget for HSS support be increased to US$700 million through 2013.

The objective of the GAVI Health Systems Strengthening (HSS) window is “to achieve and sustain increased immunisation coverage in all GAVI eligible countries through the strengthening of the capacity for the health system to provide immunisation and other health services.” In contrast to more traditional ways of funding health, The GAVI HSS framework provides innovative, flexible and predictable long term finance in support of the poorest countries. GAVI HSS has proven to be an attractive funding window to developing countries.

In 2007, WHO (with support from UNICEF) reviewed GAVI HSS proposals while highlighting distinguishing features of GAVI HSS. The HSS funding window demonstrates:

- **Systemic efforts**: the focus on overcoming system constraints to coverage and uptake of health services (rather than programmatic efforts for a specific disease).
- **Contextualised efforts**: the focus on the specific constraints individual countries experience in their particular context, rather than a one-size-fits-all blueprint
- **Bridging efforts**: the focus on bridging the programme-systems divide
- **Inclusiveness**: the promotion of involvement of all relevant stakeholders - government, civil society, health development agencies - in proposal development and implementation
- **Alignment**: the departure from classic project formats and alignment with national policies, plans, and budget cycles

GAVI HSS is already implementing and ‘pathfinding’ principles that are of high interest to the international community. GAVI Alliance support and contribution – including the HSS funding window - could be highly valuable to the International Health Partnership (IHP) signed by GAVI in September 2007, along with Ministers from developing countries and donor countries, leaders from all of the major health agencies and foundations, and two Prime Ministers. The IHP2, part of an overall Global Campaign for the Health Millennium Development Goals, is a new global compact for achieving the Health MDGs.

GAVI HSS funding window’s roll-out and achievements need to be evaluated. Many partners and countries feel the current implementation time of the GAVI HSS proposals is too short to measure impact of the investment as measured by impact indicators, and the evaluation of impact may only
show results later than 2010. GAVI Alliance partners could fail to see the value of HSS achievements that may come slowly.

It is widely understood that the 2009 HSS evaluation will inform the GAVI Alliance and Fund Boards on potential further steps or investments for GAVI HSS by providing evaluation of processes and immediate output of the proposals funded.

2. Approach and Methods
The GAVI Alliance has contracted Axios International and its collaborative partner Macro International to conduct an evaluability study of GAVI HSS. The study aims to design the evaluation framework and evaluation plan of the GAVI HSS funding window.

The table below summarizes the objectives, activities and deliverables of the study.

<table>
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<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Deliverables</th>
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<tr>
<td>Understand the context and priorities of GAVI HSS funding window</td>
<td>Review of existing documents, proceedings, meeting minutes, project applications and project reports</td>
<td>KOL and stakeholder priority conceptual mapping of GAVI HSS evaluation priorities;</td>
</tr>
<tr>
<td>Develop conceptual model(s) of GAVI HSS strategies and projects</td>
<td>Elucidate priorities of GAVI and global key opinion leaders (KOLs) in measuring and understanding the impact of GAVI’s HSS activities and how the GAVI HSS evaluation work will fit within GAVI’s overall approach to evaluation and programming;</td>
<td>Typology-specific logic model schematics identifying anticipated pathways from inputs to outputs to outcomes and impact;</td>
</tr>
<tr>
<td>Design a framework for evaluation that reflects empirical data around GAVI HSS priorities and projects</td>
<td>Identify and clarify a typology and anticipated effects of GAVI HSS efforts at the national and sub-national levels upon which to build a multidimensional evaluation framework;</td>
<td>Evaluation plan denoting underlying framework and relevant evaluation scientific and financial requirements;</td>
</tr>
<tr>
<td>Create and operationalize a model-based evaluation plan</td>
<td>Develop a comprehensive and appropriate evaluation framework for GAVI’s HSS initiative, sensitive to the needs, capabilities, and priorities of GAVI, participating nations, and global and local stakeholders;</td>
<td>Terms of Reference for implementing the evaluation plan.</td>
</tr>
<tr>
<td>Assess GAVI HSS’ readiness to implement and support evaluation</td>
<td>Create an evaluation plan that includes enunciation of core evaluative questions, data requirements, routine and one-off monitoring and evaluation studies, cost estimates and other products associated with implementing the HSS evaluation;</td>
<td>Strategic Assessment of GAVI HSS readiness, capacity, and requirements to implement full evaluation program.</td>
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</table>
2.1 Desk review and Key Opinion Leader (KOL) Priority Conceptual Mapping

A clear understanding of the context, environment, history, and priorities relating to GAVI HSS is critical to development and implementation of a meaningful, engaged, usable evaluation. To achieve this understanding, the following core activities have been implemented from November 2007 to January 2008.

2.1.1 Desk review

Prior evaluation materials, published and unpublished background documents, minutes of relevant advisory committee meetings, presentation and attendance to the GAVI HSS January 2008 forum have been reviewed in addition to GAVI HSS applications and progress reports of the projects funded. The systematic desk review approach is presented in its full report in Annex A.

2.1.2 KOL priority conceptual mapping

The first data collection step of this study involved a series of interviews with stakeholders and key opinion leaders to gather a broad range of input on perceived GAVI HSS challenges and on suggestions for the focus of the GAVI HSS evaluation. The major areas of evaluation reflect what stakeholders or key opinions leaders consider to be most important for an evaluation in the period before the 2009 country grant reallocation decisions.

In total, a sample of thirty two (32) people were interviewed between December 2007 and mid January 2008: 27 KOL and 5 SH. Some second round interviews were conducted on specific technical points, mostly during the GAVI HSS forum that took place in January 2008 in Geneva.

KOL/SH were identified in conjunction with GAVI HSS secretariat and advisors. Categories of respondents included:

- GAVI HSS project management team members, review committee members, and advisory committee members
- GAVI donors/partners and external global KOL
- In-country respondents involved in directing and managing GAVI HSS projects and activities

The purpose of the KOL/SH interviews was to gain an understanding of the opinions of respondents on the GAVI HSS themes, evaluation opportunities, and main challenges, and to generate ideas for creative, useful, and meaningful evaluation of GAVI HSS projects. The KOL priority conceptual mapping approach is presented in detail in the full report in Annex B.
2.1.3 Synthesized findings of the combined Desk Review and KOL priority conceptual mapping

This section presents an overview of the emerging priorities expressed by KOL for an evaluation framework of GAVI HSS. Desk review and KOL mapping have been the backbone of Global and in-country typology presented in chapter 3.

This section presents the emerging priorities expressed by KOL for an evaluation framework of GAVI HSS. These priorities will be further expanded and operationalized in the next phases of the project.

- **Priority 1**: How can country progress in HSS implementation be measured?
  - A monitoring and evaluation plan for following the in-country progress is perceived as the most urgent need from all the GAVI direct and indirect stakeholders interviewed.
  - In-country HSS projects are perceived as very different from one country to another, thereby limiting the ability for standardization of monitoring and evaluation procedures.
  - Most KOL confirmed the need to adapt the M&E process to the country project and context. But, KOL had different opinions on the main criteria that can be used to classify the in-country HSS projects by typology.

- **Priority 2**: How effective and efficient is the grant application process? How could it be simplified and made more participatory?
  
  The major components of the grant application process were perceived as challenging:
  
  - The complexity of the application process remains a perceived barrier to accessing the funds mainly because the partners’ participatory process requires a strong coordination of the country partners and harmonization.
  - The need to collect in the application information on how GAVI HSS fits within the broader national HSS funding picture.
  - The feasibility of decentralizing the application review process.

- **Priority 3**: How effective is the technical assistance mechanism?
  
  - Most of the respondents including country representatives would like an assessment of the technical support quality and effectiveness.
  - Respondents also expressed a need for lessons learned on better ways to provide technically support countries.

- **Priority 4**: Is the GAVI Alliance an effective mechanism for HSS? Can GAVI governance be improved?
  
  - The partnerships at the global level, and the effectiveness of the system is perceived as a priority
  - Most KOL mentioned that the inclusiveness of partners is limited
  - Minimizing fiduciary risk, implementing transparency and accountability policy
Priority 5: Sustainability of GAVI HSS principles in practice

- The GAVI HSS procedures are limiting the success of country driven principle implementation.
- KOL were interested in assessing how GAVI HSS has aligned and harmonized to national plans, country health reform strategies and other international HSS initiative.

Priority 6: How can the HSS learning process be more effective?

- If innovation is a guiding principle of GAVI HSS, some KOL expressed the need to learn from existing projects about HSS implementation strategies.
- The lack of feedback system from HSS in-country projects is perceived as a limitation to the diffusion of information mechanism and networking.

2.2 Developing conceptual model(s) of GAVI HSS strategies and projects

2.2.1 In-country process typology

Using KOL interviews and desk review analyses as a base, the project team generated a typology of projects of GAVI HSS at the national and sub-national levels upon which to build the evaluation framework. This section describes salient dimensions of GAVI HSS projects and recipients that, when aggregated, can define an in-country process typology, to be used to formulate HSS evaluation strategies for different country contexts. These dimensions include:

Redundant activities in proposal

Emerging from the KOL priorities report is the proposal to classify develop a typology based on projects and activities, rather than countries, for evaluation. Respondents indicate that these activities could be divided into the three principal thematic areas for HSS support suggested in the 2007 guidelines: (1) health workforce mobilisation; (2) drugs, equipment and infrastructure supply; (3) the organisation and management of health services; and (4) the development of funding mechanisms. A limitation of this approach is that while HSS activities may share common objectives they are typically context and country specific. Thus, applying a global evaluation framework may prove challenging.

Round when proposal was accepted (See Annex B for classification)

A second variable to include in a typology is the Proposal Round in which the country proposal was accepted (i.e. first, second, third or fourth). This approach will control for the change in the GAVI HSS proposal guidelines, which occurred in between the first and second rounds. Also, it will differentiate between countries who received funding earlier, and have therefore been able to advanced further in implementation and progress. As the GAVI HSS evaluation is planned for 2009, a short period after proposal acceptance - whether a country proposal was accepted in 2006 or 2007 may reflect how much progress it has been able to achieve. In addition, this dimension allows evaluators to evaluate proposal-related processes, such as improvements in regional and/or national coordination.
Health Systems and Coordination Capacity of Countries

A country’s health system and coordination capacity may impact the effectiveness of the GAVI HSS proposal. Classifying countries according to these respective capacities offers a third dimension for inclusion in typology development. Such capacity can be measured through several aspects, as listed below. Each category can be used separately, or a composite ranking system can be developed to classify countries into groups according to their respective capacities.

Is there Sector Wide Approach (SWAp) system in place?

- Under the SWAp, donors give significant funding to a sector-specific umbrella and commit to a defined sector policy under the government authority, within a sound macro-economic framework. KOL interviews indicate that without such Overseas Development Assistance (ODA) coordination mechanisms, GAVI HSS funding may tend to be projectized, rather than systematic. Indeed, countries where SWAps are in place are likely to have a joint review mechanism and performance monitoring system.

Is the country receiving other GAVI Alliance funding?

- Whether a country is already receiving GAVI Alliance funding (e.g. ISS, HSS, NVP etc.) may impact the effectiveness of GAVI HSS proposals. If there is already vertical funding for immunisation and projects to address MDG 4 and 5, a country may see a significant improvement in the final outcome indicators, yet these may not be attributable to GAVI HSS. Therefore, distinct evaluation tools may need to be developed.

Is the country receiving other HSS funding?

- Distinguishing between countries where GAVI HSS support is provided in addition to HSS support from other agencies/ initiatives is an important dimension of in-country resources to consider.

What are the initial conditions of the country’s health system?

- Diminishing returns to investment in health should be considered when evaluating country’s improvements. Health systems in lower-capacity countries may evolve and improve much more quickly than others.

What is the political and economic context?

- Considering the broader context of the country’s situation should be considered in the typology, as a health system in a fragile state is likely to evolve distinctly and at a slower rate than one in non-fragile state.

1 See WHO’s site on Sector-Wide Approaches (SWAps): [http://www.who.int/trade/glossary/story081/en/](http://www.who.int/trade/glossary/story081/en/)

2.2.2 Logic modeling of GAVI HSS global strategy

A logic model is proposed to help guide understanding of the overall global-level GAVI HSS strategy. Individual logic models reflecting the in-country variables described in section 2.2.1 will be created in the next phase of this project, which will guide development of context-specific evaluation plans.

Using evaluation and logic models results in more effective programming and offers greater learning opportunities, better documentation of outcomes, and shared knowledge about what works and why. Logic models are a beneficial evaluation tool that facilitates effective program planning, implementation, and evaluation. Basically, logic modelling provides a systematic and visual way to present and share understanding of the relationships among resources to operate a program, the activities planned, and the changes or results to achieve.

The Global GAVI Logic Model that follows describes the theoretical or conceptual flow of program expectations over time, from conceptualization and planning to results and impact, following a chain of reasoning that connects key steps of the programming process. The objective is to map the sequences between the planned work and the intended results. The logic model flows from left to right, with inputs and processes producing the outcomes and impacts on the right side of the model.

An explanation of the elements comprising the Global GAVI HSS Logic Model follows:

Column 1: Inputs
Inputs represent the resources, preliminary conditions and/or assumptions at the early stages of the chain (basically the conceptualization), needed to operate the HSS program.
- Technical Assistance for proposal development (and later for grant implementation)
- Health System Gaps Identification, considering in-country capacity to effectively manage grants
- Respect of the 10 GAVI Alliance guiding principles in proposal development
- Strategy for proposal development, including all key partners
- Activities targeting service delivery “bottlenecks” or barriers in the health system in the critical areas defined by GAVI (health workforce; organization and management of health services; supply, distribution and maintenance systems) and/or by the country (other sustainable areas)

Column 2: Process
If the required resources/conditions/assumptions are met, then the country proposal development and later the grant negotiation can happen.
- Proposals developed by key in-country partners and submitted by national governments (with the eventual exception of fragile states) eligible for GAVI funds
- Grant negotiation after the GAVI HSS Independent Review Committee approval, based on number of newborn children per year and GNI per capita.

Column 3: Outputs
If the proposal is awarded and the grant has successfully been negotiated, then activities can be implemented and delivery of the amount of product and/or service intended hopefully be delivered.
- Grant implementation by key in-country partners, in alignment with national health plans
- Disbursements and audit reports to ensure proper financial management

3 Adapted from W.K. Kellogg Foundation, Logic Model Development Guide, Jan. 2004
• Monitoring & Evaluation to demonstrate programming achievements and reaching of intended outcomes

**Column 4: Outcomes**

*If* the planned activities have been accomplished to the intended extent, *then* participants will benefit in certain ways.

- Health systems performance through the increase of national health systems capacity (HRD, TA, material equipment, etc.)
- Performance in immunization coverage through the increase in immunization coverage across the country, especially near targeted populations (infants, women)

**Column 5: Impact**

*If* the benefits to the participants have been achieved, *then* certain changes in organizations, communities or systems can be expected to occur.

- Health systems effects through achievement of the Millennium Development Goals 4 (reduction in infant mortality) and 5 (improved maternal health).
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Draft GAVI HSS Global-level Logic Model

**Inputs**
- Technical Assistance
  - For proposal development
- Health System Gaps
  - In-country identification
- GAVI Alliance Guiding Principles
  - Country-driven; Country-aligned; Harmonized; Predictable; Additional; Inclusive and Collaborative; Catalytic; Innovative; Results-oriented; Sustainability-conscious
- Strategy for proposal development
  - Country demand-driven
- Activities targeting service delivery “bottlenecks” or barriers in the health system
  - Health Workforce
  - Organization and management of health services
  - Supply, distribution and maintenance systems
  - Other sustainable areas

**Process**
- Proposal Development
  - GAVI eligible countries with a Comprehensive Multi-Year Plan for Immunization; Submission by National Governments, involving key partners from civil society and private sector
- Grant Negotiation
  - Budget envelope allocated based on birth cohort and per capita income, for the duration of the National Health Sector Plan, after GAVI HSS IRC review and approval

**Outputs**
- Grant Implementation
  - Technical Assistance Aligned with National Health Sector Plan
  - Involvement of key partners
- Disbursement and audit reports (APR)
  - Based on in-country procedures
- Monitoring and Evaluation
  - Data management and quality reporting to demonstrate outcomes

**Outcomes**
- Health Systems Performance
  - Sustainable increase of health systems capacity
- Performance in immunization coverage
  - Achievement and sustainable increased of immunization coverage

**Impact**
- Health Systems Effects
  - Reduction in infant mortality (MDG 4)
  - and improved maternal health (MDG 5)
3. Next Steps of the Monitoring and Evaluability Study

Our next steps will be to develop a comprehensive and appropriate evaluation framework and to operationalize a model-based evaluation plan sensitive to the needs, capabilities, and priorities of GAVI, participating nations, and global and local stakeholders.

3.1 Evaluation Framework Development

The Evaluation Framework (EF) is based upon the priorities of the GAVI HSS program, KOLs and stakeholders, and the typology of GAVI HSS projects and their associated logic models. The Evaluation Framework is an analytic document, a form of meta-logic model that graphically and analytically represents how the project typology, priorities, and evaluation expectations fit together as a comprehensive model. This analytic step will synthesize the data and analyses from previous steps into a comprehensive summary document describing the overall structure for creation of an evaluation program for GAVI HSS, based upon stakeholder input and GAVI strategy, as reflected in the project typology.

In particular, this Evaluation Framework will center around displaying, anticipating, and measuring, the following short- and long-term dimensions of GAVI HSS:

- Comprehensiveness: How do GAVI HSS projects and policies fit together as a whole? What are the underlying theoretical assumptions overall for how GAVI HSS expects to achieve its goals? Identifies intentional, unintentional, planned, and unplanned theoretical assumptions and mechanisms.
- Implementation: How are GAVI HSS activities planned, initiated, and managed?
- Effectiveness: How do individual projects, project types, and policies achieve their goals and objectives intended to accomplish?
- Efficient: How are activities produced with appropriate use of resources? How are resources measured and reflected?
- Cost-effective: How does value of benefit exceed cost of producing them? From whose perspectives?
- Attribution: How can systems-changes can be attributed to HSS window? In particular country projects, in clusters of similar projects (types), and in policies?

This Evaluation Framework – again, reflecting a meta-logic model for the entire GAVI HSS effort, rooted in the perspectives, priorities, and experiences of KOLs and projects – forms the bases for the development of subsequent strategies for its implementation and measurement.

3.2 Create and operationalize a model-based evaluation plan

The work of this objective extends beyond theoretical and analytic development and will result in the creation of a strategic evaluation plan for GAVI HSS that includes:

- Enunciation of core evaluative questions, rooted in the data and analyses that preceded this step
- Data requirements to support the operationalization of this evaluation framework;
- Subsequent routine (integrated, internal processes) and one-off (external, non-routine)
- Monitoring and evaluation studies to measure and assess the Evaluation Framework;
- Cost estimates and other products (Terms of Reference) associated with implementing the HSS evaluation on a prospective scale.
This Evaluation Plan, together with the Evaluation Framework, will comprise the strategic and operational recommendations from the Team, rooted in the priorities and expectations of stakeholders and projects, for review and implementation by GAVI.

3.3 Assess GAVI HSS’ readiness to implement and support evaluation
This objective will use the plans previously developed to provide a targeted, rapid review of GAVI’s existing monitoring and evaluation systems, and how well those systems can respond to the evaluation needs described in the Evaluation Plan. This step will be interactive with GAVI staff to conduct this rapid assessment, using the Evaluation Plan as a blueprint and checklist against which to measure current capacity. The Team will generate a summary and recommendations around how well the existing system and capacity can implement the recommended evaluation strategy, and what investments and/or changes are necessary to adapt GAVI’s existing systems to the envisioned comprehensive evaluation plan. This rapid and targeted review will focus upon:

- Existing data requirements for GAVI HSS projects, and the management and reporting of data;
- Human resources available for implementing evaluation activities and reporting on their progress;
- Information systems that support the processing and monitoring of evaluative information;
- Opportunities for collaboration and sharing of data across GAVI for evaluation;
- Costs associated with management and implementation of existing systems.

4. Deliverables and Project Timeline
The following deliverables are anticipated as result of this Evaluability Assessment:

- KOL and stakeholder priority conceptual mapping of GAVI HSS evaluation priorities;
- Typology-specific logic model schematics identifying anticipated pathways from inputs to outputs to outcomes and impact;
- Evaluation plan denoting underlying framework and relevant evaluation scientific and financial requirements;
- Terms of Reference for implementing the evaluation plan.
- Strategic assessment and recommendations for adapting current GAVI HSS evaluation capacity to meet the needs of the Evaluation Plan.

Project timeline approved by GAVI HSS secretariat within which to complete these deliverables in form is summarized in the table below. Timeline displays the workplan with tasks and deliverable completion dates. Currently, we are anticipating a two-week delay for the deliverable of the strategic assessment of readiness (final deliverable). The final deliverable is anticipated to be completed by 30 April 2008, depending upon GAVI feedback to the other deliverables.
## Project Timeline

### 1.0 Context Assessment
- **1.1 Desk Review**
- **1.2 KOL Prep**
- **1.3 KOL Interviews**
- **1.4 KOL Concept Mapping Deliverable**

### 2.0 Concept Modeling
- **2.1 Typology Development**
- **2.2 Logic Modeling**
- **2.3 Logic Model Schematics Deliverable**

### 3.0 Framework
- **3.1 Evaluation Framework Development**
- **3.2 Evaluation Framework Deliverable**

### 4.0 Evaluation Plans
- **4.1 Understand requirements**
- **4.2 Costing/ resourcing**
- **4.3 Terms of Reference Deliverable**

### 5.0 Strategic Guidance
- **5.1 Rapid review M&E Systems**
- **5.2 Evaluation Readiness Assessment**

### 6.0 Management
- **6.1 Inception meeting**
- **6.2 Internal Team Meeting**
- **6.3 Advisory Review**
- **6.4 Final Presentation and Closeout**
- **6.5 Final Deliverable Package**

### Project Timeline

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GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) is a unique organization that aligns public and private resources in a global effort to create greater access to the benefits of immunization. It does this with precision and in creative, innovative ways to ensure that donor contributions efficiently save lives and help build self-sufficiency in the world’s poorest communities and regions.

GAVI’s Health System Strengthening (HSS) program assists countries to overcome bottlenecks which often impact immunization and other child and maternal health care initiatives.

Objective of Desk Review

This desk review aims to contribute to a better understanding of GAVI HSS, its history, principles, coordination mechanisms, processes and priorities. It draws on a large and expanding body of literature and documentation sourced from the GAVI HSS share point as well as from external sources¹. It is structured as follows:

1. Objective of Desk Review
2. Context and the Objectives of GAVI HSS
4. Coordination Bodies
5. Proposal Development, and Review Processes
6. Identified Priorities and Intents of GAVI HSS Decision-Makers

Annex A: GAVI Alliance HSS Guiding Principles in Detail
Annex B: An overview of accepted HSS and CSO proposals to date

¹ database searches, internet searches, and documentation sent from GAVI staff
GAVI HSS Context and Objectives

In 2004, the GAVI secretariat commissioned a study of system-wide barriers to increased immunization coverage. This study revealed that health systems issues, such as lack of transport, shortages of human resources, and problems with health worker motivation constrained immunization coverage. Further, these barriers and bottlenecks were country-specific. Study findings initiated the development of this HSS proposal (See GAVI 2004). The proposed HSS investment had as its objective:

To achieve and sustain increased immunization coverage in all GAVI eligible countries, through strengthening the capacity of the health system to provide immunization and other health services.

In 2005, the GAVI Alliance Board decided to invest US$500 million for health system strengthening (HSS) from 2006 to 2010. These funds are intended to contribute to the GAVI Alliance’s efforts to reduce both child and maternal mortality (Millennium Development Goal 4 and 5) in a systematic manner.

In November 2007, the Board requested that the budget for HSS support be increased to US$700 million through 2013. While acknowledging the value of the HSS programme, the HSS reference group identified “make or break” risks in this increased investment: 1) countries, partners and the GAVI Secretariat could be unable to meet the demands of HSS; 2) support to health systems at the country level could be fragmented; 3) GAVI funders could fail to see the value of HSS achievements that may come slowly; 4) HSS may displace finances from government and other development partners; and 5) concrete attribution to the GAVI HSS window will be difficult.


Who is eligible to receive HSS funding?

All 72 GAVI eligible countries are eligible for GAVI HSS funding. These countries should have completed a Comprehensive Multi-Year Plan for Immunisation (cMYP) or its equivalent, which spans the duration of the GAVI HSS proposal. Only national governments can submit applications, though exceptions may apply for fragile states. In special cases where the government is unable to produce an application, the GAVI Alliance may accept applications developed and signed by key partners.

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2 This section was largely drawn from the Proposal for GAVI to Invest in Health Systems Strengthening (HSS) Support (2005): http://www.gavialliance.org/resources/Investment_Case_for_HSS_Nov05.pdf
3 The HSS Reference group was created in 2005 by the GAVI Secretariat. It is a consultative group that supports further development and implementation of HSS country support and replaces the HSS task team which developed the HSS investment case. The reference group is composed of 12 members: UNICEF, WHO, World Bank, Bill & Melinda Gates Foundation, US, UK, Norway, vaccine industry, PATH. It is chaired by GAVI Country Support Team Leader. (See “Summary of GAVI non-governance groups” 23 March 2006: http://www.gavialliance.org/resources/jec_23mar2006_A2_GAVI_non_gov_groups.pdf)
4 GAVI eligible countries are those where the latest GNI figures are equal to or less than $1000 per capita per year

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How should funding be allocated?

The ten guiding principles of GAVI HSS funding are detailed in the GAVI HSS guidelines and can be found in Annex A. These guidelines state that the HSS programme should be:

1. Country-driven
2. Country-aligned
3. Harmonised
4. Predictable
5. Additional
6. Inclusive and collaborative
7. Catalytic
8. Innovative
9. Results-oriented
10. Sustainable

In addition, the guidelines require that GAVI HSS funding be fully aligned with OECD Development Assistance Committee (DAC) principles. Finally, experiences and lessons learned must be shared with other initiatives such as PMNCH, HMN, GFATM, the Global Health Workforce Alliance, implementing countries, the World Bank, WHO and other stakeholders.

How much funding is available?

GAVI HSS funding should be aligned with the duration of the National Health Sector Plan (or equivalent) – typically 3-5 yrs. It is disbursed on an annual basis and is based on achievements highlighted in the annual progress report and reviewed by the Independent Review Committee (IRC). The country budget envelope is based on the number of newborn children and GNI per capita:

- Countries with GNI < $365 = $5/newborns year
- Countries with GNI > $365 = $2.50/newborns year

GAVI requires audit reports within one year of the close of the financial year, as well as proof that government health spending has not been displaced by GAVI HSS funding.

Where should the funding go?

Funding should address barriers and bottlenecks in the health system that impede progress in improving and sustaining high immunization coverage and the provision of other linked child and maternal health interventions. Three principal thematic areas for HSS support are suggested, but are not restricted to, improvements in:

5 These are the 2007 revised guidelines for applications, based on country feedback. Source of key principles is the GAVI HSS website; http://www.gavialliance.org/vision/policies/hss/scalingup/index.php accessed in December 2007.
7 Partnership for Maternal, Neonatal and Child’s Health
8 Health Metrics Network
9 Global Fund for AIDS, TB and Malaria
10 No progress reports have been made available
11 Based on 2004 GNI data, according to the HSS excel worksheet in the sharepoint.
12 Global Alliance for Vaccines and Immunization (GAVI) Health Systems Strengthening Core Task Team and GAVI-led HSS Forum Membership, Mandate and Functions for 2007; http://www.gavialliance.org/resources/HSS_TT_mandate_TOR_and_mandate25_January_version.doc
13 Source: see footnote 2
1. **health workforce** mobilisation, distribution and motivation targeted at those engaged in immunization and other health services at the district level and below
2. **drugs, equipment and infrastructure supply**, distribution and maintenance for primary health care
3. **the organisation and management** of health services at the district level and below (including financing issues).

### Coordinating Bodies

Coordination mechanisms and structures exist at the global, regional and country levels these mechanisms are described below.

#### Global Level

At the global level is the **Health Systems Strengthening Core Task Team (HSS-CTT)** and the GAVI-led **Health Systems Strengthening Forum (HSS Forum)**. The HSS-CTT is a 10 member team co-chaired by three multi-lateral institutions, WHO, World Bank and UNICEF. Other members include the GAVI secretariat, USAID, the Bill and Melinda Gates Foundation, DFID, Norad, a developing country representative and a civil society representative14.

The HSS forum brings together the HSS-CTT and representatives from bilateral and multi lateral donors, agencies, and other networks15. It serves as a forum to share information, generate ideas, suggest strategies and share lessons learnt and mobilise and sustain the commitment to health systems strengthening of a wider constituency.

#### Regional Level

At the regional level, **regional working groups**16 play an important role in successful support mechanisms for GAVI HSS. These consist of regional staff at GAVI Alliance partner representatives in regional offices. Various regional meetings have increased awareness and peer review mechanisms have been instituted in several regions that aim to strengthen capacity and inter-country exchanges.

#### Country Level

At the country level, there is also the **Health Sector Coordination Committee (HSCC)** which coordinates and endorses GAVI HSS processes. It also acts as the key mechanism for partner inclusion.

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15 such as the HMN, Alliance for Health Policy Research, GFATM, Stop TB, Roll Back Malaria, Global Health Workforce Alliance, PMNCH and UNAIDS.
16 Their purpose is to provide technical support to a group of countries and to represent the interests of those countries in GAVI’s global decision making-processes. They meet quarterly, and are usually hosted by WHO. Regions with working groups include West and Central Africa; East and Southern Africa; Eastern Mediterranean; South and South East Asia; Western Pacific; Eastern Europe and Central Asia, the Americas. . (See “Summary of GAVI non-governance groups” 23 March 2006: [http://www.gavialliance.org/resources/jec_23mar2006_A2_GAVI_non_gov_groups.pdf](http://www.gavialliance.org/resources/jec_23mar2006_A2_GAVI_non_gov_groups.pdf))
Proposal Development and Review Processes

Proposal Development 17
Countries are expected to take the lead in the application preparation. They have access to a grant of up to $50,000 to assist with proposal development. Specifically, the process should be led by the Ministry of Health and Planning Department (or its equivalent) in collaboration with the national immunisation program, other departments in the Ministry of Health, the Ministry of Finance, development partners and other key stakeholders. Additional information, clarification, and guidance may be obtained from in-country and regional partners.18 Furthermore, the inclusion of relevant civil society and private sector entities is highly encouraged.19

HSS-CSO Funding Window
GAVI HSS support is available to Civil Society Organizations (CSOs) in 10 pilot countries (2007 – 2008) to support and implement activities identified in the GAVI HSS proposal or cMYP. Interested CSOs must use a CSO-specific application form.21

Application Peer Review

Before the Ministries of Health and Finance sign the completed application form, it should be reviewed and endorsed by a group of qualified stakeholders at the country level, at which time it is sent to the GAVI HSS IRC for review.

Independent External Review

A GAVI HSS IRC will evaluate all applications and make recommendations to the GAVI Alliance Board on the suitability of each application for funding. The four IRC decision options are 1) approval, 2) approval pending minor clarification, 3) conditional approval pending additional information, or 4) resubmission. The IRC is divided into two subgroups: the first reviews new applications for support, the second monitors the country’s yearly achievements. (See Annex B for the Overview of HSS and CSO proposals to date.)

Priorities and Intent of GAVI HSS Decision Makers

This section aims to clarify the priorities and intent of GAVI HSS decision-makers in the development of application guidelines and in the solicitation and review of applications. When reviewing application documents, GAVI HSS decision-makers place high-priority on Health Systems Strengthening (rather than immunisation), country-driven initiatives, alignment with national priorities, sustainability, and specificity at the national and sub-national level. They place

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17 These are the 2007 revised guidelines for applications, based on country feedback. Availabe in the annex of the May 2007 HSS update: http://www.gavialliance.org/resources/HSS_Update_May07.pdf
18 World Health Organization (WHO), United Nations Children’s Fund (UNICEF), World Bank (WB), and bilateral donors (such as DFID, USAID, Norad etc).
19 Entities that provide i) immunisation or child health care services; ii) technical advice or iii) social mobilisation and advocacy for immunisation and child healthcare.
20 Afghanistan, Burundi, Bolivia, DR of Congo, Ethiopia, Georgia, Ghana, Indonesia, Mozambique and Pakistan. Deadline was 5 Oct 2007: DRCongo is the only country of the 10 that has a file in the sharepoint on CSO funding. Otherwise of the eligible countries, Afghanistan, Burundi, Ethiopia, Georgia, Pakistan have applied for GAVI-HSS financing and have been approved.
21 N.b. Support is available to all GAVI eligible countries to strengthen civil society coordination and representation through a separate civil society support window.) http://www.gavialliance.org/resources/CSO_Background_Feb07.doc Guidelines and Application form for CSO-HSS: http://gavistg3.elca-services.com/resources/GAVI_Alliance_Guidelines_for_CSO_Support_final_version_24_May.doc
low priority on innovation and defining successful model of health systems strengthening. Finally, they consider challenging priority areas to include the definition of “results-oriented” and methods of monitoring and evaluating GAVI HSS.

Five high-priority areas

Five high-priority areas in the development of GAVI HSS application guidelines, solicitation and reviews of application are identified:

High Priority 1: An emphasis of Health Systems Strengthening, not immunisation.

Recurrent and strongly emphasised in the reports, minutes and guidelines is GAVI HSS’ aim “to target the ‘bottlenecks’ or barriers in the health system that impede progress in improving the provision of and demand for immunisation and other child and maternal health services (3).”

IRC feedback from Round 1 applications stated that the application’s “current structure may tend to focus full attention on immunisation rather than on the overall health system”. The revised 2007 guidelines explicitly outline a number of important ways that GAVI HSS support differs from GAVI ISS support.

This emphasis is further illustrated in three priority areas for HSS funding as suggested in the application guidelines. These define health system barriers that impede the demand for and delivery of immunisation and other child and maternal health services.

High Priority 2: Collaborative and inclusive country-driven initiatives

Guidelines, minutes and reports promote and laud country driven initiatives that are inclusive and collaborative.

At the proposal writing level it is stressed that countries should have the application reviewed and endorsed by a group of stakeholders at country level who have the skills and knowledge to ensure that the application adheres to the guiding principles of GAVI HSS (3). Such proposals are praised. For example, among the good practices identified in the 2006 IRC report state that Congo DR showed a “clear indication of the involvement of partners,” and that Viet Nam “demonstrated a good consultative process with extensive feedback recorded”. Application guidelines also encourage a collaborative approach to implementation and call on countries “to include, and benefit from, Civil Society Organisations (CSOs) and the private sector contributions to stakeholder analyses, GAVI HSS proposal drafting and review and possible implementation. (3)

High Priority 3: Aligned & harmonised to national priorities

Reports underscore the importance of aligning HSS funded programmes with national strategies and planning cycles. Parallel or new projects are not in the spirit of GAVI HSS principles; for example, “new project management unity to manage the support is not acceptable” (1).

In proposal reviews, Cambodia’s proposal was praised for clearly explaining the harmonization of GAVI support, as was Ethiopia’s proposal which showed that current funding would fit well with other plans.

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24 Indeed alignment and harmonisation are distinct concepts. When related to national priorities as is evident in the GAVI HSS guiding principles they can be juxtaposed. GAVI HSS do not emphasise as much harmonization with other projects (i.e. Global Fund or USAID), rather harmonisation with national efforts.
High Priority 4: Sustainability

Ensuring sustainable interventions emerges as an important priority in meeting minutes and in the guidelines; however, after round 1, the pre-review team identified disconcordance between the GAVI HSS principle of sustainability and the application process: “There is no explicit mention to aspects of sustainability of the intervention. This could be addressed by asking countries to explicitly explain how they plan to assume the intervention once the support is withdrawn from GAVI” (2).

The 2007 guidelines now emphasise that applications “should show how these expenditures (especially the use of funds to cover recurrent costs) will be sustained when GAVI HSS are no longer available” (3).

High Priority 5: Specificity at national and sub-national levels

GAVI HSS decision-makers emphasise country specificity, and if possible at a disaggregated and sub-national level. For example guidelines emphasise:

“the selection of and use of indicators should benefit peripheral levels, as outlined in the WHO / UNICEF Reaching Every District (RED) strategy….Any of these indicators may be further disaggregated (if the country feels this would be useful) to include information on geographic / gender / urban rural or private / public differences, which could help further guide program implementation” (3).

Ethiopia’s proposal in particular was praised for addressing sustainability.

Two low priority areas

Two low priority areas were also identified based on a review of available documentation. These are innovation and defining successful models of health systems strengthening.

Low Priority 1: Innovation

Although innovation is among the 10 principles of GAVI HSS, it is sparsely mentioned in board meeting minutes, pre-review or IRC feedback reports. Rather, there is more emphasis placed on concretely illustrating how funds will be aligned with National Health Sector Plans. Nevertheless, in the most recent board meeting reports (Nov 2007), three of the 20 proposals discussed were lauded for their innovative strategies. Still, the report itself mentions innovation only once25. As GAVI HSS establishes itself, a larger space may emerge for innovation.

Low Priority 2: Concretely defining a successful HSS model

Throughout the documentation, there appears to be an implicit understanding of what a successful HSS model is. ‘Success’ is most often defined in country and context specific terms. This is in line with the country-led principle that allows countries to identify challenges and bottlenecks particular to their health system, then to develop relevant strategies to tackle challenges. Emphasising country specificity poses difficulty in developing a single generalisable definition of a successful HSS model, so defining a successful HSS model has not been prioritised.

25 A word count in the report finds innovation once, in the following quote which addresses the International Health Partnership (IHP) “the IHP framework can further highlight the ability of GAVI to provide innovative, flexible and predictable long term finance in support of the poorest countries” (5)
Challenging priority areas

Two priority areas where decision-makers have had difficulty developing concrete operational approaches include: 1) defining ‘results-oriented’, and 2) how to go about monitoring and evaluating GAVI HSS. These two areas are related, as positive results imply a positive evaluation. These will therefore be addressed jointly.

**Challenging priority areas: Identifying results and Monitoring & Evaluation**

Although M&E is highly prioritised, decision-makers are unclear on how to go about it. Two tendencies emerge in the documentation: impact / output oriented results and process oriented results. The former emphasises the three overall impact / outcome indicators outlined in the 2007 guidelines (i.e. national DTP 3 coverage, numbers / % districts achieving 80% DTP3 coverage, under five mortality rate.) The latter emphasises a more process-oriented approach that captures increased coordination at the country, regional and global level. Indeed, first round IRC feedback indicates that “[o]utcome indicators are mostly related to coverage of PCH interventions. Qualitative /policy related indicators are nearly absent”.

These two are weakly reconciled in the most recent available GAVI board meeting minutes that states that “[m]any partners and countries feel the current implementation time of the GAVI HSS proposals is too short to measure impact of the investment as measured by impact indicators, and the evaluation of impact may only show results later than 2010. It is widely understood that the evaluation will, none the less, provide evaluation of processes and immediate output of the proposals”.

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26 “There are huge and complex needs for monitoring, evaluation and operational research.” (4)
Key documents for further details (not exhaustive list of documents used):

- Comments and suggestions from GAVI HSS pre-review team. Geneva 11th to 16th March 2007 (GAVI HSS Sharepoint)
- Executive Committee Report of The Health Systems Strengthening Independent Review Committee 10-20 November 2006 (GAVI HSS Sharepoint)
- For meeting minutes between 2006 and 2007 please see GAVI HSS Share Point http://hss.gavialliance.org
- Global Alliance for Vaccines and Immunization (GAVI) Health Systems Strengthening Core Task Team and GAVI-led HSS Forum Membership, Mandate and Functions for 2007 http://www.gavialliance.org/resources/HSS_TT_mandate_TOR_and_mandate25_January_version.doc

Key for citations in Section 6:

1. Executive Committee Report of The Health Systems Strengthening Independent Review Committee 10-20 November 2006 (attached to e-mail sent with this desk review)
2. Comments and suggestions from GAVI HSS pre-review team. Geneva 11th to 16th March 2007 (attached to e-mail sent with this desk review)
4. Draft meeting notes for the Health Systems Strengthening (HSS) Task Team Meeting: Geneva December 11-12, 2006 (Share point)
Annex A: Guiding Principles in Detail

1. **Country-driven**: Support is intended to address weaknesses identified by implementing countries. They are encouraged to use recent immunisation programme and health sector analyses, National Health Sector Plans and similar inputs to identify weaknesses and gaps in current funding.

2. **Country-aligned**: HSS should be consistent with the existing objectives, strategies and planning cycles of government health sector policy, aligned with government management systems and financial procedures, and reflected in national budgets wherever possible.

3. **Harmonised**: HSS should add value to (not compete with) current or planned efforts to strengthen the health systems by national governments, civil society and health sector partners.

4. **Predictable**: HSS support is, in principle, available for the life of National Health Sector Plans (or equivalent).

5. **Additional**: HSS funds must be additional to the government’s existing budget and not displace previously allocated health sector resources.

6. **Inclusive and collaborative**: All key stakeholders (beyond immunisation) should be involved in HSS. Government entities, partners, civil society, and the private sector should all be informed and involved, as appropriate, in the planning, implementation and evaluation stages.

7. **Catalytic**: HSS should not result in the creation of stand-alone, independently managed projects. Ideally, it should be an agent for catalytic change where possible – for example, testing pilot projects that could subsequently be scaled up by government.

8. **Innovative**: GAVI encourages health service innovation. HSS can be used to test new strategies or approaches or to adapt learning and best practice from elsewhere.

9. **Results-oriented**: Implementing countries must link strategies for tackling barriers to specific indicators that show how use of HSS funds will improve immunisation and other forms of child and maternal health care. The results should be evident at local level. Progress towards agreed goals will be monitored by GAVI Alliance partners including WHO, UNICEF, the World Bank and the Health Metrics Network.

10. **Sustainability**: Implementing countries must take into consideration how the recurring financial and technical requirements of health service improvement of HSS support can be sustained beyond the period of GAVI support.

*Source: Revised Guidelines for GAVI Alliance Health System Strengthening (HSS) Applications March 2007*
Annex B: Overview of accepted HSS and CSO proposals (as of Nov 2007)

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## GAVI HSS proposal typologies (29 Proposals) (Preliminary)

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GAVI HSS Evaluability Study
Appendix B: KOL Priority Mapping
February 2008
GAVI HSS KOL Priority mapping

Introduction

The GAVI Alliance has subcontracted Axios International and its partner Macro International to conduct an evaluability study of the GAVI Alliance’s Health Systems Strengthening programme (HSS). The study aims to design the evaluation framework and evaluation plan of the GAVI HSS funding window. The first step of this study involved a series of interviews with stakeholders and key opinion leaders to gather a broad range of input on perceived GAVI HSS challenges and on suggestions for the focus of the GAVI HSS evaluation. The major areas of evaluation should reflect what key respondents or key opinion leaders consider to be most important for an evaluation in the coming 2 years before the 2009 country grant reallocation decisions. This report presents the results of these interviews in terms of perceived priorities for guiding the GAVI HSS evaluation program design.

Methodology

The information provided in this report was collected through interviews with key opinion leaders and stakeholders. Key opinions leaders (KOL) are defined as those individuals at the global level with direct decision-making impact upon GAVI HSS. Stakeholders (SH) are defined as those within the implementation chain who participate in and/or benefit from its programs. In total, thirty two (32) people were interviewed between December 2007 and mid January 2008: 27 KOL and 5 SH. Some second round interviews were conducted on specific technical points.

The purpose of the KOL/SH interviews is to gain an understanding of the opinions of respondents on the GAVI HSS themes, evaluation opportunities, and main challenges, as well as to generate ideas for creative, useful, and meaningful evaluation of GAVI HSS projects.

KOL/SH were identified in conjunction with GAVI HSS secretariat and advisors. Categories of KOL/SH engaged included:

- GAVI HSS project management team members, review committee members, and advisory committee members
- GAVI donors/partners and external global KOL
- In-country respondents involved in directing and managing GAVI HSS projects and activities

A participatory approach was used to engage the KOL/SH in sharing their perceptions about GAVI HSS. Semi-guided interviews were conducted by phone or face-to-face during the 3 day GAVI annual meeting at GAVI Geneva. A discussion guide was sent to the interviewees prior to the study to help focus the interview. The qualitative questions were open and broad during this phase to make sure that unknown salient challenges or evaluation topics of interest were not missed.

This report serves as an initial survey of respondents’ opinions and will contribute to elaborating the HSS logic modelling and evaluation framework. The most salient priorities are presented in this report.
Summary of observations

General observations of interview process

Both SH and KOL seemed intensely involved and identified strongly with the GAVI HSS initiative. They consistently described GAVI HSS as different from other initiatives, and innovative in the way this initiative works. They put a strong focus on the “learning by doing” or “learning from mistakes” approach of this initiative. Within that sentiment, they expressed an awareness of the responsibility that comes with the development of such an initiative.

While there were many different perspectives expressed on the potential focus of a GAVI HSS evaluation, the interviewers found that all participants genuinely and conscientiously engaged with the initiative and have tried to steer, adapt and change it to the maximum of its capacity. Most of the interviewees had a lot of information that they wanted to share to maximize the benefits of this investigation phase. Some interviewees were even ready to discuss evaluation questions and evaluation methods, which demonstrates the urgency of this evaluability study to GAVI HSS team members.

The interviewers also found that the comments of some respondents perhaps would require going beyond monitoring and evaluation of GAVI HSS models and would require operational research; but this document reports the priorities for evaluations as they have been expressed and perceived by the participants.

Perceived strengths and weaknesses of GAVI HSS

When speaking about GAVI HSS, the respondents mentioned mostly the following distinctive features that characterize the HSS initiative best and determine the GAVI values:

- “It’s a predictable and flexible funding” said a KOL.
- GAVI-HSS is not a program for a specified disease (or immunization) and focuses on overcoming system constraints to coverage and uptake of health services.
- “GAVI use a contextualized approach”, said a KOL explaining that funds are open and adapted to country context/experience.
- Some KOL explained that GAVI is a “pathfinder approach” promoting “learning by doing” design.
- GAVI-HSS tries to involve all relevant respondents in proposal development (national representatives, civil society and health development partners). “HSS is really promoting the inclusiveness principle”, said another KOL.
- Aligned and harmonized funding mechanism to national health and financial policies, plans, and budget cycles. A KOL explained that “you cannot find [HSS] applications for funding window more open and flexible to suit the national project plans and procedures than the GAVI HSS form! You cannot!” insisted a KOL.
- GAVI is a large scale initiative: “it is not a pilot program as the geographical focus of GAVI HHS puts an emphasis on all 72 GAVI-eligible countries”, said one KOL.
- GAVI HSS approach contributes to better understanding of aid effectiveness and to Global Health Agenda. “There is no progress without risk”, said a KOL. Another one asked during Geneva meeting in presence of all partners: “Thank you to GAVI for having organized this meeting, it’s the first time that I see all the HSS specialists around the table for discussing this
strategic aid to developing countries, it’s evidence-based and how efforts could be coordinated”.

- Other KOL perceived GAVI HSS as a very new approach - “GAVI HSS is slightly different from any other initiative in this area, and very innovative by its design and flexibility”, said a KOL.

These characteristics of GAVI HSS need to be taken into account in the design of the evaluation program plans. But, during the desk review process, the evaluation team noticed that distinctive features of GAVI HSS varied from one document to another and from one respondent to another (table 1).

Table 1: Fundamental principles of GAVI HSS as described in the documentation

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During the interviews, respondents highlighted that GAVI HSS is a good initiative, but it is not perfect. They described the following weaknesses of the GAVI HSS funding window:

- Flexibility of the grant allocation process remains “a fiduciary risk” as expressed a KOL (very limited contractual procedures are in place between GAVI and MOH)

- The coordination of funds and partner activities at country level remain weak. “In some places, you can see – and it happened everywhere - partners’ interest and focus are on similar activities, it’s so much wastage and losses! Everybody wants to train, and nobody wants to build roads”, explained a KOL.

- The KOL perceived most of the time that there is no technical assistance and management support provided to funded country for improving the implementation of HSS: “how can the countries show results if there are even not capable of spending the money and if they don’t have the staff expertise to implement the project?”, “where are the HSS technical assistants?”.

- KOL agreed to say that impact and attribution evaluation of GAVI HSS cannot be done: “you won’t be able to show impact”, “attribution, don’t think about it”, “I would like to see the attribution but I know it is not possible”.

- Some KOL explained “as health Millennium Development Goals are not HSS driven, the positioning of GAVI HSS is challenging”.

- GAVI is perceived as “a pathfinder for other organizations”: solutions for improvement are not easy to identify. “We do not have references to replicate an HSS large scale strategy, everybody is looking at us but we are learning by doing” summarized a KOL.

The perceived major weaknesses of GAVI HSS correspond to the emerging priorities for an evaluation framework of GAVI HSS developed in the next chapter.
Emerging priorities for an evaluation framework

**PRIORITY 1 = How can country progress in HSS implementation be measured?**

Overall, respondents had various opinions of the role of GAVI HSS, the selection and use of indicators, and the process of monitoring and evaluation, though they mostly agreed on points such as the need for country evidence-based progress and an incoherence between the timelines set out for implementation and results.

To begin with, all respondents participating in the evaluability study mentioned the need for **country evidence-based progress** in strengthening their national health system to convince the donors to invest long-term and to improve the grant allocation process. GAVI HSS presents itself as a performance-based initiative and promotes this philosophy in its reference documents\(^1\). However, some respondents prefer to speak about “results-oriented decision making process” because only limited quantitative indicators are collected at country level and quality of implementation is not taken into account at this stage in the M&E country plans.

- “We need to know what the countries are doing”, said one respondent.
- “We wants to know which country has reached its target”, said one respondent.
- “We have no clue on the country progress, I want to know where the issues are”, explained a respondent.

Another challenge identified by the respondents is that the HSS implementation timelines and expected results from countries do not match the implementation timeline does not correspond to real project progress. With a timing of 2009 as the main limiting factor for a GAVI HSS evaluation, most of the respondents agreed that the impact and sustainability of the GAVI HSS funding window will not be relevant in such a short timeframe. Respondents also agreed that only **output and outcome HSS indicators at country level** need to be monitored. They explained that timing of implementation is driven the selection of indicators: process indicators can be collected at the inception of the program, output indicators can be used at medium-term and outcome indicators can be measured at the long-term.

- “We can focus on process indicators at the beginning of the project, the time needed to build the coordination system, and then you will start seeing the first results of the project”, described a KOL.
- “As most of the projects start from ground zero, they should create their management mechanism. We can look at the management system that has been built to supervise the project, and then follow the results, number of people trained, vehicles bought, etc. If we can show the impact of the HSS on immunization after many years of infrastructure improvement, that will be a successful evaluation plan”, explained a stakeholder.

The respondents had different perceptions about what should be the focus of outputs and outcomes indicators. The main challenge for the interviewees was the lack of clarity on what roles GAVI HSS should play at the country level and the definition of the GAVI HSS mandate: should it be a funding agency or a technical agency specialized in immunization systems implementation? Following are the arguments suggested by the respondents in favour of either of these two mandates.

1) **GAVI HSS as a funding window**

\(^1\) Investment case, November 2005
A minor group of respondents strongly believes that GAVI HSS should be a financing agency.
- “GAVI HSS is nothing more than a funding window, we are not the managers of the project implementation, we are only interested in verifying where the money is going”, explained a KOL.
- “As GAVI HSS members, we should just check that countries received the money, and that cash management system tracking is efficient and effective”, think another KOL.
- “Our role gives us the power to exclusively require transparency in the budget spending” think another KOL.

From this perspective, GAVI HSS performance would be based on the in-country capacity to manage the funds, implement standard operating procedures and quality assurance procedures. A minority of respondents expressed the need to evaluate the country accountability of HSS funds. The overall argument is that donor pressure (G8, Gates, IFFm) is increasing for HSS in-country results and evidences of rational management of funds. Furthermore, some respondents expressed the need to evaluate the following fiduciary issues:
- “Review and assess in-country GAVI HSS fund flow mechanisms and accountability”
- “Overview of TAP and use of SWAP mechanisms”
- “Conduct tracking study in country mechanisms”
- “Assess how GAVI funds are reflected in MOH budget or in the Ministry of Finance budget”
- “Assess the absorption and spending capacity (frontloaded funding)”
- “Assess the transaction cost”

When asked about the typology of GAVI HSS program implementation, the respondents of these groups distinguished different types of fund management mechanism: the SWAPs fund flow mechanism and Non-SWAPs. They recommended adapting the evaluation approach to the financial mechanism typology implemented in country.
- “We can categorize the countries by the quality of their funding management mechanism, I expect a SWAP country or a country experienced with another financial model to be more capable of showing HSS impact indicators within the 2 years of program implementation, than a country starting from scratch”, said a KOL.
- “The efficiency of the funding management system set up in country determines the success of implementation in a short timeframe”, said a KOL.

2) GAVI HSS as a program to strengthen immunization systems

A majority of respondents were not interested in focusing on GAVI HSS monitoring of country financial management capabilities. They saw this activity as part of a broader set of HSS activities implemented to strengthen in-country immunization systems and impacting immunization coverage in the long-term. Their interest focused on evaluating the direct or indirect benefits of HSS funds on the national immunization system and understanding to what extent some countries have been able to use HSS funds to strengthen their health systems. Fund performance would be assessed in the short term through process indicators of HSS implementation progress at country, regional, and district levels:
- Health workforce mobilisation, distribution and motivation (has it progressed and improved?)
- Drugs, equipment and infrastructure supply, distribution and maintenance (including transport) (has it progressed and improved?)
- The organization and management of health services (has it progressed and improved?)
- Funding mechanism/accountability (has it progressed and improved?)

When asked about the **typology of GAVI HSS implementation**, 2 distinctively different arguments emerged:

a) **Adaptation of the evaluation methods to the type of activities implemented.** Respondents supporting this argument referred to the major types of activities conducted in countries/project type. They recommend adapting the evaluation methods to the type of activities implemented. For each activity, a set of standard quantitative indicators (process and capacity indicators) could be suggested to the country. The country would have the choice to select and adapt the most relevant indicators monitored in alignment with the national M&E system, EPI program and HSS M&E system. One KOL used the following example: “if the type of HSS in-country project is “motivation of health workers,” all countries with this type of activity could choose the monitoring indicators among a pre-defined list and adapt them to the country: “has the turnover reduced in the site x?” can be selected”. Another KOL said “some types of activities are frequently proposed in the applications, the approach can be slightly different, but you can find some top broad strategies”.

b) **Defining typology based on project activities is impossible.** Respondents bringing forward this argument thought that there cannot be a typology of HSS activities because the HSS project and context are too different from one country to the next. One possible alternative suggested was to distinguish countries approved during round 1 from countries approved during round 2. In other words, the evaluation type would depend on the level of implementation and experience with HSS. Another suggestion was to distinguish between countries based on their level of health system capacity following pre-defined World Bank economic indicators. Fragile states would have a specific type of evaluation. “The typology will be the experience of the country with GAVI HSS, recent program can not show outcomes indicators like old programs”, suggested a woman. “You can not expect the same level of performance from a very poor country than from an emerging country. You have to find a way to implement evaluations adapted to the level of health system capacity and country environment”, explained another KOL.

Regardless of their perspective on a typology of implemented programs, respondents also had differing opinions of the **type of indicators and data collection methods** that should be used. In most cases, the respondents agreed that measuring GAVI HSS fund contributions to in-country HSS made more sense than measuring attribution. Most of the respondents agreed that outcomes could not be attributed to GAVI HSS for the following reasons:

- The upstream non-specific nature of the input: “the results of GAVI HSS are due to the activities undertaken to reach the targets. These activities can indirectly impact the expected results limiting the linkage between impact indicators and activities”, detailed a KOL.
A timeframe of 2 years doesn’t allow for measuring attribution, given that round 1 countries started implementing HSS in 2007.

By design, GAVI is complimentary to funding from other donors and organizations. “It is designed to fill the gap between other projects, so any achievement or failure would be dependent on the combination of all interventions and cannot be linked to GAVI by itself” said a KOL. “Maybe, you have to look at what are the other donors for strengthening the national health system: if a country received only GAVI HSS fund for one set of activities, you can maybe speak about attribution performance indicators”, explained a KOL.

Respondents suggested two approaches to identifying indicators and data collection methods. These perspectives are:

a) Option 1: the indicators should be predefined and countries should select from a suggested list of indicators proposed at the global level. These indicators would be monitored in-country and reported annually to GAVI. Baseline indicators should be in the application or baseline assessment should be done in year 1.

b) Option 2: some respondents (a minority) spontaneously mentioned the need to promote the use of country specific qualitative and quantitative information and policy related indicators. As the quality of the in-country M&E depends on country experience, time investments and capacity, in-country M&E will remain weak for 2009. The evaluation team should aim to identify the direct and indirect effects of HSS in-country, identify the country dynamics/changes created or accelerated by GAVI, and measure how GAVI HSS has contributed to change the system. The need is to understand the “HOW and not the WHAT” through annual or biennial evaluations.

To illustrate this argument, respondents raised questions about the positive and negative effects of GAVI HSS in-country:

“Has Health Systems Strengthening been high on government’s agenda?”
“Have fund coordination mechanisms been set up?”
“Were new approaches to in-country coordination funded (within government units)?”
“Are partners harmonizing their activities? Are they doing joint visits now?”
“Are CSO engaged in the proposal and implementation process?”
“What is the level of satisfaction of health workers? Has it increased? Has HSS created distortions, parallel structures, not sustainable beyond HSS?”
“What are the unintended effects of GAVI HHS, distortion on Health Systems?”
“Has GAVI HSS created opportunities for ‘niche’ financing but also innovation (i.e. performance-based funding, public-private partnerships, contracting approaches, incentive schemes)?”
“Do interventions address the right constraints?”
“Has the implementation plan been improved?”
“What are the catalytic effects of HSS funding?”
“Has GAVI HSS helped strengthening of national capacity in all aspects of development of strong proposals?”
“Has GAVI HSS created inter-country exchange about HSS: peer review and peer support?”
“Has it fostered domestic partner support? Has dialogue among partners increased?”
“Has HSS communication, research and diffusion evolved in-country?”

The respondents also had different perspectives on how country progress could be better monitored and/or evaluated and raised the question of whether or not global experts were the best people to monitor country progress. Broadly speaking, respondents can be split into two groups:

1) Those who think that country progress should be monitored through the Annual Progress Reports based on indicators identified in advance. It would require baseline indicators (collected through systematic baseline study or applications) and GAVI would use a panel of health system indicators pre-defined in advance or defined by countries.

2) Those (the minority) who think that country progress assessment should be based on periodic evaluations (after 2 years). It was recommended to do semi-qualitative contribution of GAVI to the national HSS. To maintain the oversight and ownership at country level, it could be a self-evaluation done by countries in collaboration with multilateral agencies.

**PRIORITY 2 = How effective and efficient is the grant application process? How could it be simplified and made more participatory?**

Overall, respondents expressed the need to evaluate the appropriateness of the application development process, its review process and its approval process. In particular, respondents expressed their interest in understanding how the application process could be better coordinated and improved. Some country representatives and some respondents participating in application development pointed to the complexity of the application process. They stated that at the inception of the funding window and for a considerable time thereafter tools and guidelines were perceived as complex. Respondents have since noted an improvement; however, application development remains complex.

- “You have to evaluate the application development process and recommend the lessons learnt from this phase to improve it; excellent guidelines, guidance from TA and coordination mechanism could facilitate the process”, said a KOL.
- “I spent quite some time in going through the guidelines to figure out what I am supposed to do”, said a stakeholder.

The country representatives explained that the complexity of the process comes from the level of effort required for coordinating the partners’ opinions, roles and responsibilities in country. Indeed, the GAVI HSS application process is defined as a participatory process involving civil society representatives and multilateral partners from national and regional levels, in-country partners, local government representatives, and implementing partners. In practice, the coordination process of all these partners is challenging in some countries. The lack of consensus quickly becomes a barrier to the speed and quality of the proposal development process. Moreover, some respondents explained that the process of finalizing the administrative proposal remains difficult: the final agreement and signature of the proposal are challenging, especially when the HSS project involves sub-national partners. However, the partner coordination mechanism is perceived as a necessity for HSS in-country planning success and as encouraging a collaborative approach to implementation. The level of effort required to mobilize the respondents and partners is perceived as a critical step towards maximizing alignment and harmonization success.
- “What is the most challenging in the proposal development process is the design of the project in collaboration with the partners”, insisted a KOL.

- “We have spent months in discussing processes and administrative issues with partners, this step should happen for the success of the project, but when you are in the middle of a grant proposal development process, you want to minimize the time you can allocate to this activity”, explained a KOL.

The evaluation of the grant process is expected to be focused on the following questions raised by stakeholders:
- “How could the HSS proposal development process be simplified by coordinating and engaging the HSS partners?”
- “What are the lessons learned from the GAVI HSS proposal development process?”
- “How have Civil Society Organizations (CSO) and the private sector been engaged in the process?”
- “What approach has worked well?”

One proposal was to conduct an in-depth study of previous experiences in proposal development to highlight instances of respondents’ successful engagement and coordination of activities.

Some respondents pointed out that the application form lacked information that would capture country context and poorly explained how GAVI HSS fits within the broader HSS picture. An evaluation of the different ways of contributing to the national health system would help to understand what type of information would need to be captured in the proposal in addition to: “what are the country HSS partners? What are their roles and responsibilities in HSS? How would they be coordinated? What are the other HSS funds?” suggested a stakeholder. “You need to know how GAVI HSS fits with the other funds, are the donors paying for the same thing? Has the country coordinated the implementing partners”, proposed a KOL.

Once a proposal was approved, some countries faced problems with the disbursement of funds. When countries are approved, the approval has to be endorsed by GAVI and it takes an average of 5-6 months to sort out bank accounts. Respondents spoke of a disproportionate time lapse between being informed that the proposal was accepted and actually receiving funding. Respondents frequently pointed to country specific financial processing mechanisms as the main reason for this lag. Better coordination and proposal preparation (including fund flow and management procedures) could facilitate the process and not delay the HSS implementation. Some respondents suggested that questions about the financial set-up procedure already be addressed in the proposal development process. “After our approval, he took us 4 months to figure out how we are going to receive the funds, we didn’t realize how important it was during the proposal development phase”, explained a stakeholder.

As GAVI HSS does not have country representation, the application pre-review and review process typically is done at the global level. Some respondents expressed the need to decentralize the review process. They would like to evaluate how regional or country HSS actors could be involved in the application review process. “What are the risks?”, “Is it feasible?”, “What could be the most tangible options?”, “if decentralization is not feasible, how could the proposal development process be used to stimulate a dialogue between global team members and country representatives before the submission of a proposal?” said different KOL.
Concerning the grant application process, some respondents expressed interest in identifying proposals that have not been funded and to evaluate those proposals to identify the challenges and barriers to accessing GAVI HSS funds: lack of information, lack of expertise etc. The respondents also found it relevant to study which countries have not submitted a proposal and why. KOL proposed to pose the following questions: “were they aware of the process?”, “do they have information available at the country level to justify their project?”, “what are the characteristics of the countries that did not submit a proposal?”

**PRIORITY 3 = how effective is the technical assistance mechanism?**

Another area of evaluation is the technical assistance mechanism. Most of the respondents including country representatives have some concerns regarding technical quality and effectiveness. There is a need to “evaluate the performance of the technical assistance for proposal writing and how well they are engaging the local partners” as explained a stakeholder. “The consultant work needs to be reviewed periodically”, insisted another stakeholder. “The TA come for one week and don’t take the time to assess our capabilities and the potential partnership that could be created”, explained a country representative. Multilateral technical assistance is also perceived as a limiting factor of country contextualization. Many KOL would like to ask the question “are the consultants performing well?” It was suggested to assess the quality of proposals done by consultants to see if the HSS proposals have been contextualized and funded. The evaluation is expected to lead to: 1) an identification of the areas where assistance is needed, and where, why and how the assistance has been helpful; 2) country categories of in-country HSS capacity to develop proposals; and 3) a list of consultants approved by the international organizations.

Respondents also expressed a need for lessons learned on better ways to provide technically support countries: “was the presence of technical assistants in country justified? How could the proposal process stimulate support for national and regional institutes and support for minimum standards, country driven approach, and feedback from countries?” suggested a KOL, “the evaluation would need to provide some recommendations on how to get away from reliance on international consultants”, proposed another one. “I am not saying that the TA are not expert, I am speaking about the efficiency of the process vs GAVI principles”, insisted another GAVI stakeholder.

**PRIORITY 4= Is GAVI Alliance initiative a good mechanism? Can GAVI governance be improved?**

The GAVI Alliance model has been defined as a complex initiative that includes many HSS multilateral agencies, donors and unilateral aid. Some respondents expressed the need for proof of GAVI success and the need to evaluate this partnership: “you should evaluate if it is working well? What are challenges of the system itself?”, asked a KOL. “Is the partnership concept a good way of improving immunization services?”, said another partner.

Respondents also indicated that there is a need to evaluate arrangements at the global level, as well as the effectiveness of the system. The KOL would like to know the following: “are technical assistance, task force team members and IRC members collaborating well?”, “Should the donors comment on applications?”, “What are the roles and responsibilities of the partners and where are the conflicts of interest (multiple roles of UNICEF and WHO)?” Is there political pressure?”

Inclusiveness of partners is perceived as a major characteristic of GAVI HSS, but at the same time, the partnership with Civil Society Organisations and other national or regional agencies or
partners is limited. The following questions suggested by the interviewees summarize the major inclusiveness limits identified: “did the GAVI Alliance succeed in engaging civil society and the private sector? GAVI HSS does not have in-country presence. GAVI HSS does not have country coordinating mechanisms. Is this good or not?” Some respondents would like to know “if it’s a good initiative to promote country driven principles or if it’s a barrier to inclusiveness of partners”.

Some respondents mentioned that the main challenge of the application review process is the lack of HSS expertise among reviewers. Financial specialists, transport managers, human resources managers, health information system and supply chain expertise should be represented at the proposal review committee to assess the relevance of the proposed HSS national plans. “I strongly recommend doing an in-depth analysis of the applications to identify the expertise from the private sector that should be recruited to optimize the HSS alliance network” was suggested by some KOL. “Most of us are immunization specialists; do we know how to manage a national transportation plan? No, do we know how to implement a large scale strategy for motivating the health workers? No”, explained a KOL.

**PRIORITY 5 = GAVI HSS principles**

Although GAVI has not yet endorsed the Paris Declaration, the vision and principles of GAVI are generally in line with the Paris Declaration. Among the 10 guiding principles of GAVI HSS listed below, the first three were the priority critical principles that needed to be evaluated:

- Country driven,
- Country aligned,
- Harmonized,
- Predictable,
- Additional,
- Inclusive and collaborative,
- Catalytic,
- Innovative,
- Results orientated,
- Sustainability conscious,

Results of the interviews showed that some factors are limiting the country driven principle of implementation. Indeed, predefined proposal templates and administrative requirements, suggested M&E indicators, rapid technical assistance and too much involvement of multilateral partners, delays in proposal agreements from multilateral partners, types of clarifications requested of country representatives may limit country oversight. Others see this type of guidance as contradictory to the principle that programmes should be country-driven and that there should be opportunities for country representatives to build their capacity for project management. “Why is it really country-driven? Is it because the country should develop the proposal themselves? They have at least 3 indicators to collect, requirements to follow, reporting process not linked to the country budget cycle and SWAP mechanism is highly promoted! It is country-driven, if you follow our rules!” think a KOL. Some respondents identified the need to assist countries by providing a maximum amount of guidance”. “How can develop country expertise if the application review process is not decentralized to the regions, and if TA are developing the proposal?” said a KOL.
The alignment and harmonization to national plans and country health reform strategies in country remain challenging. Some respondents explained the contradictions between alignment and harmonization principles and practices.

- At country level, GAVI HSS is promoting the SWAP mechanism and asks for Annual Progress Reports, including a minimum of standard indicators. These requirements are not always aligned with country context: “annual reports may not coincide with national cycle report, SWAP mechanisms may not be the best approach in some countries with recent experiences in this system”, said a woman, “in-country M&E systems do not allow to track the requested information unless there is a revision of the GAVI HSS proposal budget”, explained another person. Reports underscore the importance of aligning HSS funded programmes with national strategies and planning cycles. Parallel or new projects are not in the spirit of GAVI HSS principles; for example, “new project management unity to manage the support is not acceptable is written in the IRC review notes”, explain a KOL. In proposal reviews, Cambodia’s proposal was praised for clearly explaining the harmonization of GAVI support, as was Ethiopia’s proposal which showed that current funding would fit well with other plans. Another finding is that the proposal templates do not systematically take into account how aligned and harmonized an HSS project is with in-country partners, other sources of HSS funding and national plans. The recommendation suggested by some KOL is “to develop some sections of the application to capture how GAVI HSS funds are inscribed in other HSS funding windows and plans”. The respondents would like “to assess how well GAVI HSS is integrated within the national system and the national strategy”.

- At the global level, some respondents mentioned that GAVI HSS has not endorsed the Paris Declaration and is not collaborating “concretely” with the Global Fund or the World Bank and with regional multilateral partners or the recent international partnership (The International Health Partnership) for aligning and harmonizing the application process or grant mechanism, etc. Some questions were raised by the stakeholders: “what is the future landscape and international multilateral collaboration for HSS funding mechanism?”. “The evaluation needs to understand how GAVI HSS fits with the MDGs and other multilateral agency strategies, as well as where the limit of alignment and harmonization is”.

**PRIORITY 6 = How can the HSS learning process be more effective?**

GAVI HSS is a type of funding window within the GAVI mandate that is run differently from the other ISS, INS, HSS funds, etc. Some respondents mentioned that GAVI HSS aims to be an innovative funding mechanism of cross-cutting activities, a new funding mechanism to strengthen ISS. “GAVI HSS is a new approach to international aid to developing countries, that’s why we don’t know how to evaluate it”, said a KOL. While GAVI HSS leaders are promoting the innovation as strength of this initiative, some respondents do not perceive GAVI HSS as innovative as it was supposed to be and do not ask for an evaluation of GAVI innovation: “it’s really not the point now!” said a KOL. However such a difference between “value” and stakeholders perceptions shows a need for evidences. GAVI HSS at the global and country levels. The KOL raised the questions “What is the added value of GAVI HSS in term of innovation?”, “how has GAVI contributed to a better understanding of aid effectiveness?”, “Is the innovation linked to in-country immunization system strengthening approach?”, “Is innovation referring to global health aid effectiveness strategy and HSS initiative or is it just a communication strategy?”

Some respondents even think that GAVI HSS is becoming a gap filler of the national health plans because of the flexibility of GAVI HSS funding mechanisms compared to other multilateral agencies. Some country representatives explained that GAVI HSS is perceived as a funding
opportunity for strengthening HSS back office activities that could not be funded by other donors. “Without GAVI HSS funds, we could have access to funds for developing our project, developing management skills project cannot be accepted by other donors”, explain a stakeholder. “What you should do is an in-depth study of applications and national plans to assess the links between national proposals and immunization systems” or “evaluating innovative principles is interesting only if you demonstrate some HSS models in countries that we can used as lessons learnt", were proposed by two different KOL.

Communication was an underlying salient issue indirectly expressed by the interviewees when explaining the gaps between country implementation and global level expectations and strategies. The major challenges expressed were:

- The lack of feedback loop in the GAVI HHS process
- The need to share experiences regarding HSS during proposal development and implementation
- The need for a platform of expertise (international, regional, national and sub-national expertise) and HSS regional networking for technical assistance
- Supporting learning and sharing of information through regional observatories/research networks
- Establishment of global knowledge databanks related to HSS
- Support for additional operational research focusing on innovation and global public goods from HSS proposals
- Coherent communication strategy between global and in-country and global dissemination strategy
- Workshops for peer reviews and comments from experts on draft proposal

Some respondents consider that this international, regional, national and sub-national dynamic emerging through GAVI HSS needs to be tracked and used for individual country team performance. Some KOL said “HSS is a so recent in some countries that program managers are starting to build systems and processes, you can not show the impact, but you can show what the country is building”, “indirect effects of GAVI HSS or system building show a minimum of the country performance”.

**Recommendations for the GAVI HSS Monitoring and Evaluation**

From the results outlined above, the following recommendations for GAVI HSS Monitoring and Evaluation can be made:

- Develop a simple evaluation plan focusing on 3-4 issues;
- It is widely understood that the evaluation will, nonetheless, provide an evaluation of processes and immediate outputs of the proposals in the short timeframe. The respondents recommend further to explore the impact of GAVI on in-country processes;
- The M&E GAVI HSS plans for in-country implementation should be aligned and harmonized within the national HSS project:
a. GAVI HSS decision-makers emphasise country specificity, and if possible at a disaggregated and sub-national level

b. M&E evaluation (including indicators) at country level should be driven or decided by countries

c. Self-evaluation capacity at country level should be strengthen
d. The evaluation design should strengthen the national M&E design and management capacity;

- The M&E GAVI plans should be aligned and harmonized with international initiatives:

e. The overview of work areas and how these may add to International Health Partnership

f. The HSS working groups should collaborate (inter, intra-multilateral agencies) and promote operational research
g. Use existing data sources and explore gaps and needs in the GAVI HSS models to share lessons learned for HSS and implementation strategies;

- Success criteria of GAVI HSS evaluation differ greatly. Success is most often defined in country and context specific terms. Emphasising country specificity poses difficulty in developing a single generalisable definition of a successful HSS according to the KOL interviewed. The major success criteria of GAVI HSS evaluation were categories in 7 items below:

1. Show some evidence of improvement at country level (GAVI HSS actually increased the routine vaccination, show added value of GAVI HSS for countries)

2. Show attribution is ideal for GAVI donors

3. Understand how the countries are implementing their program (lesson learned-based approach)

4. Demonstrated that GAVI HSS processes need to change (too flexible)

5. Show equal number of problems and successes

6. The evaluation is focused on context and processes at global, regional and country levels

7. Country ownership of HSS management and decision making.

To conclude, the interviewees have various perspectives on GAVI HSS performance, challenges and evaluation questions that they would like to explore. To summarize, respondents found that the GAVI Alliance HSS strengths were that it provides predictable funding, emphasizes system-wide change, is inclusive, and is implemented on a large scale. The major weaknesses identified were that funds and partners are poorly coordinated, that there is not enough technical assistance management support, and that an impact and attribution evaluation of GAVI HSS cannot be done. The flexibility of the GAVI HSS is the strength and the weaknesses of this initiative and the M&E framework will in a way delimit and reframe the GAVI HSS approach.

Information gathered from respondents provided material for the creation of 6 priority areas for evaluation:

1. Measuring country progress
2. Grant application process
3. TA mechanism
4. GAVI governance
5. GAVI principles
6. HSS experience learning process

In particular, respondents converged on the need to focus the GAVI HSS evaluation at different levels (global and in-country). The need to generate lessons learned is urgent and a frequently recurrent request. The topics of interest covered various dimensions of GAVI HSS:

- ALL interviewers expect evidence-based country progress (from the financial management standpoint or immunization systems standpoint).

- The processes used at the global and country levels are expected to match GAVI key principles (application development, review of application and Annual Progress Reports, inclusiveness, technical assistance)

- The GAVI HSS initiative is based on partnership and country specificity requiring strong coordination mechanisms that have not yet shown their effectiveness.
Consultancy Services for Conducting a Monitoring and Evaluability Study for GAVI Health System Support to Countries

Deliverable 2
April 2008
Axios International
Paris, France

Macro International
Calverton, Maryland
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- Table 1 (Attachment) -
  Proposed Evaluability Questions and Indicators for GAVI (2009) and in-country (2009-2012)
I. Introduction

GAVI HSS seeks to shift the paradigm of funding from being project-based to functioning as a funding window, representing a significant monetary commitment of initially $500 million (2005) and an additional $300 million (approved in February 2008) until 2015. The benefits of this shift are expected to be: increased flexibility to support health system strengthening, with closer integration with and alignment to in-country national health plans and strategies; enhanced partner engagement; and expanded capacity building at country level.

So how does the evaluation of a funding window differ from that of “projectized” funding? Projects are often defined by hard boundaries of time, place and resources with specific pre-defined targets that are often more easily evaluated in terms of inputs, outputs and outcomes, since what is “in” and what is “out” of the project is often quite clear. Evaluation of the impact of projects is often possible, as the boundaries of project-based funding usually make attribution of effects somewhat possible. Sustainability and capacity-building are key challenges in project funding, as systems and infrastructure can often be built parallel to what already exists, and resources are typically time-limited, with little focus on sustainability planning.

While recognized as an important and valuable shift in approach, the funding window is not without its challenges and complexities. Funding windows, by definition and intent, purposefully blur the lines between what is included and what is not included in the project, as there is no ‘project’ in the traditional sense of the word. Emphasis is placed on building on existing systems and structures, and on extensive partner involvement. Often, the inputs, outputs, and outcomes are blurred in terms of funding support as well. Given this blurring, making connections between funding and observed improvements in something as broad as HSS, is often difficult, and attribution to a specific funding stream becomes nearly impossible. Although attribution of observed impact is not of primary concern for funding windows, it poses a problem for evaluation purposes, as impact cannot always be linked to a particular input. The melding of inputs through funding window approaches often means that funding windows are more easily assessed systematically in terms of processes, outputs, and intermediate outcomes; however, efficiency and effectiveness are difficult to quantify without the link to inputs.

The relative newness of this funding approach, to both GAVI as an organization and to the countries who are eligible to submit proposals, presents a critical learning opportunity. The processes or policies established by GAVI can be examined in light of the submitted proposals, their review and approval, and the monitoring of the effectiveness of the funding. Moreover, and most meaningful to this GAVI HSS monitoring and evaluability study document, the evaluation of GAVI organizational processes can be undertaken, not in a silo, but in relation to what is happening at the country level, thereby highlighting any potential synergies or barriers deriving from GAVI policies and procedures. This monitoring and evaluability study takes the approach that the proposed evaluation in 2009 will bring to light important relationships and insights from these early phases of GAVI HSS funding that can be used to improve the effectiveness and efficiency of the funding window in later phases, both at the organizational and country levels.
II. Approach to Step Two: Developing a conceptual model for an ideal evaluation of the GAVI HSS funding window

In the original proposal for this monitoring and evaluability study, it was envisioned that typologies of GAVI HSS-funded country activities would be useful for conceptualizing how an evaluation of the funding window should be designed. It was thought that a logic model approach would efficiently describe a basis for an evaluation framework. Step One of the evaluability study, which included the desk review, Key Opinion Leader interviews, and the Inception Report, clearly showed that the objective of “non-projectization” of the GAVI HSS funding window creates sufficient blurring at the level of inputs to make a logic-model approach somewhat artificial. In-depth discussions with the GAVI Secretariat, HSS Task Team and Steering Committee further clarified the importance of including both GAVI HSS organizational and in-country processes in the proposed evaluation framework and differentiating what could be assessed in the near term (2009) and what would likely not be ready for evaluation until later (2012). What emerged was a need to focus not on country typologies and logic models, but on conceptualizing the types of evaluation questions that need to be addressed, given the common bottlenecks and processes that countries face when accessing the GAVI HSS funding window.

Diagram 1: Approach to GAVI HSS Evaluation Plan Development

The second step of the GAVI HSS evaluability study endeavoured to identify the key evaluation questions that ideally should be addressed at both the country and organizational levels. In this process, the 29 country proposals and relevant material from the GAVI Sharepoint - including the GAVI HSS investment case - was reviewed, along with the 2007
WHO health systems strategy, the common framework for monitoring scale-up developed by IHP+, and frameworks for evaluating other HSS initiatives.\(^1\)

The attached table presents a menu of evaluation questions which are organized according to five key process steps in accessing and utilizing GAVI HSS funds, which can be considered to be the potential components of the evaluation framework:

1. Proposal Design/Development and Approval Process
2. Design and Implementation of GAVI HSS-funded activities
3. Management of GAVI HSS funds
4. Monitoring and evaluation of GAVI HSS-funded activities
5. Possible outcomes of GAVI HSS funding support

These components represent the key processes identified through Step 1 of this monitoring and evaluability study, and also where both GAVI organizational and in-country processes intersect. Within each of these components is a menu of potential evaluation questions and associated indicators that can be assessed in 2009 and 2012. The “Level of Inquiry 2009” column specifies either the GAVI organizational or country levels; intersection of the country and organizational levels can be seen where both are listed. Potential data challenges, questions to be resolved and concerns or issues are identified in the comments column.

A key assumption underpinning the approach to Step 2 is that the five proposed components of the 2009 evaluation will focus primarily on processes and experiences, assessing the process “infrastructure”, such as policies, systems and implementation. This implies that qualitative research approaches will be central to the 2009 evaluation, and used alongside any available quantitative data. The 2009 evaluation should also include an assessment of progress against output indicators (where feasible), and determine the gaps in both data and monitoring systems that need to be addressed prior to the 2012 evaluation. The 2012 evaluation should shift focus slightly to include a greater emphasis on outputs and outcomes within each of the five proposed components, as well as intermediate outcomes that compose the fifth evaluation component. Another assumption is that the evaluation will take into account country contextual differences, such as having fragile state status, and the availability of SWAps and PRSPs.

Furthermore, the 2009 GAVI HSS evaluation should also determine how the GAVI HSS funding window can be made more effective and efficient, by linking country-level experiences with GAVI organizational policies (where relevant), and maintaining a focus on improvements that GAVI can make internally, taking into account other HSS funding streams and partners. By creating this linkage within each component, the GAVI HSS 2009 evaluation will more clearly demonstrate the interdependence of these processes and by extension, the interrelatedness of the issues and their potential solutions.

There will likely be opportunities for more in-depth or more frequent data collection through the proposed GAVI HSS tracking studies and the assessment of GAVI knowledge base. The evaluation may also provide information that can be used to strengthen the provision of technical support to GAVI HSS implementers. As these other initiatives evolve, it will be necessary to ensure that the design of the 2009 and 2012 evaluations incorporates and coordinates with these opportunities.

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\(^1\) HS 20/20 project of USAID: System-Wide Effects of the Fund (SWEF), and Global HIV/AIDS Information Network (GHIN). The team tried, without success yet, to review a draft version of the HSS Dashboard of indicators being developed by WHO.
III. Next steps

The attached table conceptualizes an ideal model for evaluating the GAVI HSS funding window. It assumes unlimited time, resources, and consistent data availability.

Whereas, Step 2 describes the ideal questions and indicators that one would like to look at in order to understand the GAVI HSS Funding Window, Step 3 operationalizes these questions into details that a team of evaluators can gather in a systematic manner taking into consideration limits on time and availability of information. Step 4, which is the development of the actual evaluation plan, will include practical indicators based on the operationalized details along with data sources, collection methods and sampling options. The evaluation plan will describe timeframes and terms of references for evaluators as well as provide details about how country-level studies should be designed, taking into account the specifics of the country’s HSS activities and M&E indicators, relevant contextual factors such as SWAps, as well as the common elements to be evaluated across all countries.
### Table 1: Proposed Evaluability Questions and Indicators for GAVI (2009) and in-country (2009 and 2012)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Is the quality of proposals improving?</td>
<td>Approval rates by round Re-application rates; # countries applying more than twice % of applicants receiving proposal TA Sources of proposal TA Approval rates of TA-supported proposals v. non-TA supported proposals Adequate targeting of activities to bottlenecks Gap analysis in proposal Cost estimation process Relevance to national HSS strategies (where relevant)</td>
<td>GAVI Secretariat IRC Proposals</td>
<td>Time trends in approval rates % of applicants receiving proposal TA Sources of proposal TA Approval rates of TA-supported proposals v. non-TA supported proposals</td>
<td>Much of the data on proposal and approval rates exist at the Secretariat, but is not organized for systematic monitoring</td>
<td></td>
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<tr>
<td>Is the proposal review process of sufficient quality?</td>
<td>HSS expertise representation on IRCs, by round Time between application, review, and notification to countries Documentation of review process Monitoring systems for proposal review process Information availability to applicants and others re. proposal review comments/recommendations Country satisfaction with review and communications from GAVI</td>
<td>GAVI Secretariat IRC reports IRC members</td>
<td>Documentation of review process Monitoring systems for proposal review process Information availability Time trends in country satisfaction with GAVI communications and review process</td>
<td>GAVI HSS IRC may consider developing a standard report format for each review process, to allow monitoring over time</td>
<td></td>
</tr>
<tr>
<td>What were the roles of partners, both in country and globally, in the proposal development process?</td>
<td>Map of partner roles in proposal steps Roles played by national coordination committees</td>
<td>Country studies</td>
<td>Time trends in partner roles for proposal development</td>
<td>Diminishing partner roles may indicate increasing country capacity, not decreased coordination</td>
<td></td>
</tr>
<tr>
<td>Is proposal development capacity being developed at the country level?</td>
<td>Role played by external TA v. country partners Documentation of key stakeholder roles in cost estimation process Documentation of key stakeholder roles in bottleneck analysis and activity design Documentation of key stakeholders roles in HSS gap analysis Perceived capacity building contribution of TA Country expertise of TA provided</td>
<td>Role played by external TA v. country partners % key stakeholders centrally involved in proposal development process still playing a role in HSS or immunization Changes in key stakeholders if new proposals developed</td>
<td>Source of TA, particularly external v. regional v. local, will be important to monitor over time</td>
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</tbody>
</table>
### Evaluation Component 2: Evaluation Design and Implementation of GAVI HSS-funded activities

<table>
<thead>
<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Level of inquiry 2009</th>
<th>Indicators 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are activities adequately addressing bottlenecks?</td>
<td>Changes made since proposal design Revisions to documentation/analysis of bottlenecks in proposal Progress on activity-specific monitoring indicators (for Round 1 countries only)</td>
<td>Proposal review Country studies Progress reports</td>
<td>Identification of new or additional bottlenecks Changes made to or new activities added % of funding used for new or changed activities Progress on activity-specific monitoring indicators (more countries than 2009)</td>
<td>Key issue – are the activity changes evidence-based?</td>
</tr>
<tr>
<td>Has partner coordination improved as a result of GAVI HSS?</td>
<td>How many partners were identified in original proposal? Were partner roles in implementation explicit in proposal? How many partners are involved in the implementation What % of original partners are involved post implementation? What % of implementation partners were not part of original proposal? Are partner roles during implementation explicit? Are measurable deliverables and clear objectives identified? Have roles changed from original proposal?</td>
<td>Country studies Proposal review</td>
<td>How many partners are involved in the implementation What % of original partners are still involved in implementation? Reasons for drop out What % of implementation partners were not part of original proposal? Are partner roles during implementation explicit? Are measurable deliverables and clear objectives identified? Have roles changed over time? How, and why?</td>
<td>Changes observed in partner roles need to be placed in the context of a changing environment, and linked with changes in activity design and implementation that may have been necessary. A dynamic framework for partner roles, which adjust to changing needs, should be advocated.</td>
</tr>
<tr>
<td>Did critical contextual factors change during implementation (e.g. SWAp, environmental conditions, funding shifts)?</td>
<td>Were contextual factors explicit in the original proposal? What percent of original contextual factors continue to be relevant at the time of implementation? For those contextual factors that are no longer relevant, what changed and why? What new contextual factors are operating during implementation? How are they accounted for in activity design and M&amp;E?</td>
<td>Country studies Proposal review IRC reports</td>
<td>What new contextual factors are operating during implementation? How are they accounted for in activity design and M&amp;E?</td>
<td></td>
</tr>
<tr>
<td>What are the operational constraints to implementation of GAVI HSS funds?</td>
<td>What operational constraints were identified in the proposal? What operational constraints have been encountered during implementation? How are they being addressed? Do they differ from those identified in original proposal?</td>
<td>Proposal review Country studies</td>
<td>What operational constraints have been encountered during implementation? How are they being addressed?</td>
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<tr>
<td>What are the systemic constraints to implementation of GAVI HSS funds?</td>
<td>What systemic constraints were identified in the proposal? What systemic constraints have been encountered during implementation? How are they being addressed? Do they differ from those identified in original proposal?</td>
<td>Proposal review Country studies</td>
<td>What systemic constraints have been encountered during implementation? How are they being addressed?</td>
<td></td>
</tr>
<tr>
<td>What is the role of technical support for GAVI HSS implementation?</td>
<td>% countries requesting and receiving TA for implementation # of implementation TA requests and receipts, per country Identification of common implementation TA needs Sources, SOWs, deliverables, and costs of TA received Partners roles in facilitating access to TA Comparison of countries that used proposal development TA to those that received implementation TA</td>
<td>Country studies Partners</td>
<td>% countries requesting and receiving TA for implementation # of implementation TA requests and receipts, per country Sources, SOWs, deliverables, and costs of TA received Partners roles in facilitating access to TA Balance of proposal development and implementation TA</td>
<td></td>
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</tbody>
</table>

### Evaluation Component 3: Management of GAVI HSS Funds

<table>
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<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Level of inquiry 2009</th>
<th>Indicators 2012</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can disbursement efficiency be improved from GAVI to country level?</td>
<td>Average time from proposal approval to first disbursement Average subsequent disbursement time % of disbursement requests that can considered “delayed”</td>
<td>GAVI Secretariat Country studies</td>
<td>Time trends in average disbursement time and delays</td>
<td>GAVI Secretariat needs to develop more systems to allow for regular monitoring</td>
</tr>
<tr>
<td>How are GAVI HSS funds managed once in country?</td>
<td>% approved proposals that identify the responsible fund manager/recipient % countries that changed fund manager identified in proposal Reasons for changes</td>
<td>Country studies HSS partners</td>
<td>Time trends in: % approved proposal that identify the responsible fund manager/recipient % countries that changed</td>
<td>Working with other HSS partners to allow easy collection of comprehensive data on HSS funding will be a key objective for 2012</td>
</tr>
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2 Defined as: Constraints to service delivery and coverage that operate at the district or sub-district level; i.e., constraints that can reasonably be expected to be alleviated by making additional resources available, or through re-organization efforts that are under the control of the district or sub-district managers

3 Defined as: Constraints that require action or resources at levels upstream from service delivery implementation; i.e., higher than district level, and often involving multiple partners
| How is procurement using GAVI HSS funds managed? | Commodities, equipment, vehicles, infrastructure and goods procured to date – itemized list and costs | Country studies | Commodities, equipment, vehicles, infrastructure and goods procured to date – itemized list and costs
Changes in procurement tender processes – who, how; integration with national standards
Auditing processes – national standards v. GAVI requirements
Assessment of potential for funds misuse | Aligning with national procurement standards and guidelines difficult when standards and requirements are different and local capacity does not exist |
| What is the value added of GAVI HSS funds? | GAVI HSS funds as a proportion of overall HSS budget
Number of other HSS funding streams
Map of contribution of GAVI HSS funds and activities to national HSS strategy (where possible)
Perceived advantages and disadvantages of GAVI HSS funding, compared to other funding streams | Country studies | Time trends in:
GAVI HSS funds as a proportion of overall HSS budget
Number of other HSS funding streams
Map of contribution of GAVI HSS funds and activities to national HSS strategy (where possible)
Qualitative assessment of GAVI HSS v. other HSS funding streams
Additionality of GAVI HSS funds | While additionality and fungibility of funds is often of great interest, their measurement is challenging and often not feasible – planning is needed if either is to be assessed in 2012 |
### Evaluation Component 4: Monitoring and evaluation of GAVI HSS-funded activities

<table>
<thead>
<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Level of inquiry 2009</th>
<th>Indicators 2012</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Is there a responsible party identified for in-country monitoring and evaluation?</td>
<td>Lead M&amp;E organization identified in the proposal - reasons for selection</td>
<td>Proposals</td>
<td>Changes made in M&amp;E leads during implementation - reasons</td>
<td>Changes in indicators used for M&amp;E can show flexibility and learning, but make comparisons over time difficult; GAVI should consider developing a policy regarding</td>
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<td>Changes made in M&amp;E leads during implementation - reasons</td>
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<td>M&amp;E TA sought and received by country or lead M&amp;E organization</td>
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<td></td>
<td>M&amp;E TA sought and received by country or lead M&amp;E organization</td>
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<td>SOW, deliverables, sources and cost of the TA?</td>
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<tr>
<td></td>
<td>SOW, deliverables, sources and cost of the TA?</td>
<td></td>
<td>Current capacity in lead organization for M&amp;E of GAVI HSS activities and performance</td>
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<td></td>
<td>Current capacity in lead organization for M&amp;E of GAVI HSS activities and performance</td>
<td></td>
<td>M&amp;E capacity among other implementation partners</td>
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<tr>
<td></td>
<td>M&amp;E capacity among other implementation partners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What indicators are used for monitoring GAVI HSS funding performance?</td>
<td>% process, output and outcome indicators in proposal</td>
<td>Proposals</td>
<td>Changes made in indicators during implementation – reasons why</td>
<td></td>
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<tr>
<td></td>
<td>% indicators in proposal are part of existing in-country data collection/reporting</td>
<td>Current workplans</td>
<td>% process, output and outcome indicators currently used</td>
<td></td>
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<tr>
<td></td>
<td>Of existing indicators, % that are: in place throughout country</td>
<td>Progress reports</td>
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<td></td>
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<td>Country studies</td>
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<tr>
<td>Are indicators appropriate for measuring progress of activities?</td>
<td>Logical links between process, output, and outcome indicators</td>
<td>Proposals Current M&amp;E plans Country studies</td>
<td># of indicators per activity At least one output per activity captured Gaps in capturing performance</td>
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<tr>
<td>How do current indicators map against global HSS frameworks?</td>
<td>Map of country indicators against WHO HSS 6 building blocks Map against IHP+ framework</td>
<td>Proposals Country studies</td>
<td>Map of country indicators against WHO HSS 6 building blocks Map against IHP+ framework</td>
<td></td>
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<tr>
<td>What M&amp;E systems are in place? What is their quality?</td>
<td>Data collection systems in place for all &quot;new&quot; HSS indicators Quality assurance processes in place for all GAVI HSS M&amp;E data Geographic coverage of GAVI HSS M&amp;E reporting Are there additional ‘new’ indicators being developed, different from the original proposal?</td>
<td>Country studies Progress reports</td>
<td>Time trends in: Data collection systems in place for all HSS indicators Quality assurance processes in place for all M&amp;E data Geographic coverage of M&amp;E reporting</td>
<td></td>
</tr>
<tr>
<td>Is GAVI HSS M&amp;E aligned with national systems? Harmonized with other HSS M&amp;E requirements?</td>
<td>% GAVI HSS indicators that are part of existing in-country data collection/ reporting systems % of GAVI HSS indicators that are used for M&amp;E reports to other HSS funders Of the common indicators, % that use the same definition</td>
<td>Country studies</td>
<td>Time trends in: % GAVI HSS indicators that are part of existing in-country data collection/ reporting systems % of GAVI HSS indicators that are used for M&amp;E reports to other HSS funders Of the common indicators, % that use the same definition</td>
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</tbody>
</table>

Changes made in indicators during implementation – reasons why % process, output and outcome indicators currently used % current indicators are part of existing in-country data collection/reporting Of existing indicators, % that are: -in place throughout country -have established quality control/checks What HSS categories do proposed indicators represent (e.g., across which WHO dimensions) % current indicators are part of existing in-country data collection/reporting Of existing indicators, % that are: -in place throughout country -have established quality control/checks
Is evaluation or reporting data used or fed back for implementation improvement?

Feedback mechanism(s) identified in proposal
Data use plan in proposal
Current evidence of data use and feedback
Map of M&E reporting and feedback – stakeholders and partners involved
Satisfaction with feedback and data use support, esp. at district level

Country studies
Proposal review

Current evidence of data use and feedback
Map of M&E reporting and feedback – stakeholders and partners involved
Satisfaction with feedback and data use support, esp at district level

Link with documented changes in activities – were they data-based?

Do countries plan for evaluation of GAVI HSS funding?

Evaluation plan in proposal
Evaluation plan developed after proposal

Country studies
Proposal review

# of country-level evaluations of GAVI HSS conducted

While most workplans are clear on monitoring, the evaluation aspect of M&E is often not developed

**Evaluation Component 5: Possible outcomes of GAVI HSS funding support**

<table>
<thead>
<tr>
<th>GAVI HSS Evaluation Questions</th>
<th>Indicators 2009</th>
<th>Level of inquiry 2009</th>
<th>Indicators 2012</th>
<th>Comments</th>
</tr>
</thead>
</table>
| What progress is being made on indicators identified in the proposals? | % of proposals with baseline data for all indicators
Quality assessment of baseline indicators
Disbursement rate and actual time of activity implementation
Changes in indicators since proposal (for countries with adequate implementation times – possibly only round 1) | Country progress reports
Country studies | % change in indicators | Since countries and activities within countries will have different implementation periods, progress will have to be broken out by round or intervals of implementation time (e.g., less than 1 year, 1-2 years, etc.) |
| Have GAVI HSS M&E requirements contributed to strengthening country M&E systems, including routine HIS? | Data collection systems in place for all proposed HSS indicators
Quality assurance processes for GAVI HSS M&E data used for other M&E data
Geographic coverage of GAVI HSS M&E reporting | Country studies | Quality assurance processes for GAVI HSS M&E data used for other M&E data
HSS M&E harmonized into one system | |
| What effects has GAVI HSS funding had on donor coordination for HSS? | # of in-country donors who use the GAVI HSS proposal as reference/planning tool
Participation of donor partners in proposal development and implementation
Perceived impact of GAVI HSS on donor coordination | Country studies | # of in-country donors who use the GAVI HSS proposal as reference/planning tool
Participation of donor partners in implementation and technical support
Perceived impact of GAVI HSS on donor coordination | At the global level, GAVI participation and leadership in HSS initiatives should also be linked |
<p>| What effects has GAVI HSS funding had, if any, on strengthening service delivery? Has that had an impact on community perspectives on district health services? | Baseline community assessments of service delivery | Country studies | Community assessments of service delivery, focusing on changes from 2009 | In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Design of activities funded by GAVI HSS, relative to other HSS activities in country</th>
<th>Country studies</th>
<th>Changes in utilization rates of services, by district, related to the proportion of overall GAVI HSS funding at central level</th>
<th>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>What evidence is there that GAVI HSS funding contributes to better access to district health services?</td>
<td>Design of activities that target service quality improvement funded by GAVI HSS, relative to other HSS activities in country</td>
<td>Country studies</td>
<td>Changes in service quality, related to the proposal of funding dedicated to service quality activities in GAVI HSS funding and overall</td>
<td>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</td>
</tr>
<tr>
<td>What potential contributions has GAVI HSS funding made to improving service quality?</td>
<td>Cost per service unit (per immunization, or full set of immunization) – establish baseline</td>
<td>Country studies</td>
<td>Cost per service unit (per immunization, or full set of immunizations)</td>
<td>In cases where GAVI HSS funding was targeted to specific districts, can compare GAVI to non-GAVI districts</td>
</tr>
<tr>
<td>What potential contributions has GAVI HSS funding made to increasing efficiencies in service delivery?</td>
<td>Identification of marginalized groups, areas Assessment of capacity to measure equity changes Plan in place for assessing baseline equity in immunization coverage Baseline measure</td>
<td>Country studies</td>
<td>Changes in immunization coverage among marginalized groups v. non-marginalized Perceived changes from marginalized group perspective</td>
<td>May be difficult to measure equity early enough to find changes by 2012 This could present a an opportunity for a participatory approach to capacity-building</td>
</tr>
<tr>
<td>Has GAVI HSS funding made any contributions more equitable immunization coverage?</td>
<td>Baseline measures of health workers, M&amp;E capacity, financing, etc. Stakeholder assessments of principal challenges and opportunities for sustainability</td>
<td>Country studies</td>
<td>Changes in baseline measures</td>
<td>In 2009, it may be necessary to first define sustainability from a country’s perspective</td>
</tr>
<tr>
<td>What is the likely sustainability of GAVI HSS-funded activities?</td>
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