



GAVI Health System Strengthening

Support Evaluation

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Sierra Leone Desk Study

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Submitted by

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Summary of key findings, conclusions and recommendations

Sierra Leone is one of the world's poorest countries. According to the latest UNDP Human Development Index (2006) it was ranked at 179th, the bottom position. It has some of the lowest indices for maternal and child health in the world. The maternal mortality rate was estimated at 1800/100,000 live births in 2007¹. A Sierra Leonean woman faces a 1 in 6 lifetime risk of dying from a pregnancy or childbirth related condition. For every woman who dies, it is calculated that another 15-30 women will face long-term health complications. The under 5 mortality rate was estimated at 262 with more than 1 in every 5 children dying before reaching their fifth birthday¹.

The focus of Sierra Leone's GAVI HSS proposal is on addressing health issues related to women and children. A number of key bottlenecks in the health system are identified that must be tackled if the health situation is to improve. These bottlenecks include:

1. A large proportion of the population does not have adequate access to priority health care.
2. Very few health facilities provide Basic Emergency Obstetric Care.
3. Majority of the Peripheral Health Unit (PHU) staff are not trained in the Integrated Management of Childhood Illnesses (IMCI).
4. Inadequate means of transportation for prompt referrals of severe and complicated cases.
5. Irregular supervision of PHU staff, one of the causes of poor quality care.

The proposal design included objectives that addressed each of the five identified barriers to delivering high quality health care. Proposal design was very much focused on helping the country to make progress towards the achievement of the Millennium Development Goals (MDGs) 4, 5, and 6.

The GAVI HSS funding has been programmed to implement activities intended to support the achievement of four main objectives intended to tackle the barriers identified above. Given the acute lack of resources of all kinds in the sector, there can be a high degree of confidence that GAVI HSS funds represent necessary and additional resources for the sector.

¹ UNICEF

Expenditure to-date has been minimal. Given that funds were only received in September 2008, the MoH did not have much time to get things underway before the end of 2008.

The GAVI proposal is fully aligned with the priorities identified in the National Health Plan and with Sierra Leone's PRS which formed the basis for the NHP.

Sierra Leone's financial year runs from January – December enabling alignment with the GAVI planning and budget cycles. In terms of alignment with budget and financial management procedures, GAVI HSS resources, are "on plan" but it is not clear if they are also "on budget".

GAVI HSS funding is being used to support the implementation of the NHP. In that sense it can be said to be fully aligned with national plans. However, the GAVI HSS funds are managed and reported on separately and have their own bank account which is operated by the MoH. The GAVI HSS programme does use the existing MoH Health Information System for reporting purposes although the GAVI APR report is developed separately. This must be a time consuming process in a MoH that is hard pressed for human resources.

The Ministry of Health designated its Department of Planning and Information (DPI) to lead the HSS proposal preparation process. All members of the Health Task Force, WHO Representative, UNICEF Representative, the World Bank Task Team Leader for the RCH, the DFID Regional Health Adviser for RCH, the Minister of Health and Sanitation and the Minister of Finance endorsed the proposal.

All of the foregoing demonstrates the commitment of the MoH to making the GAVI HSS programme as collaborative and accountable as possible. However, the real challenges will come during implementation where maintaining the commitment and input of partners will become more difficult.

The main focus of the GAVI HSS funding in Sierra Leone is on the training of a large cadre of health workers in IMCI and b-EMOC and then on ensuring that there are adequate resources available for transport, outreach and supervision. In this sense, the GAVI HSS resources can be described as very results orientated. The MoH has developed a good monitoring and results framework which should adequately reflect progress that is achieved.

The challenge will be in the effective implementation of the programme and the accurate reporting of progress made. The good quality of the 2008 APR is some indication that the MoH and its partners are prepared to invest sufficient resources in programme reporting.

Sierra Leone is one of the world's poorest countries. There is much to be done in order to build an effective and sustainable economy and health system. Realistically, the MoH is going to require significant donor support for many years to come.

The GAVI HSS activities are likely to have a substantial impact on the performance of the health system. If GAVI funding were to be withdrawn, this would have a serious impact on a number of these activities unless and until alternative sources of funding could be identified.

1. Scope, Approach and Methodology

1.1 Background

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

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 2.

1.2 Brief conceptual framework of the Evaluation

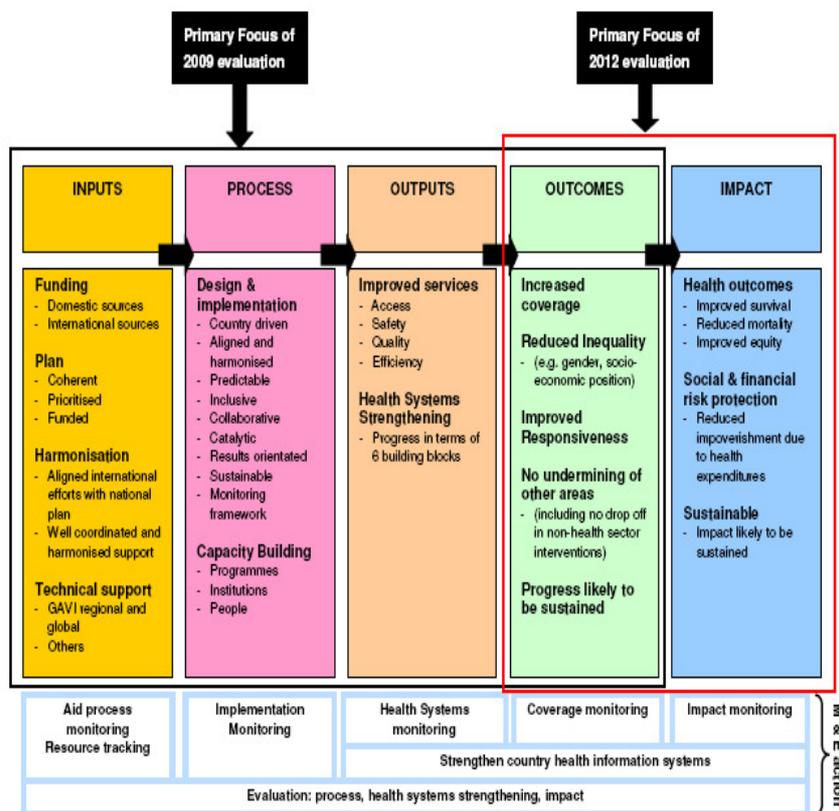
This evaluation is being conducted to inform three areas of decision making:

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

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation –the first one ever conducted on the GAVI HSS component- will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and

national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

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



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

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

1.3 Approach to the Sierra Leone Deeper Desk Studies

The Sierra Leone Deeper Desk Study used a combination of document review and telephone interview in order to gain insight into how GAVI HSS funding has support health system strengthening more generally in the country. Both the document review and interviews took place in June 2009. Annex 1 provides a list of resources used for the Sierra Leone desk study. This information complemented a thorough 2008 Annual Performance Review that gave the most up to date information about GAVI HSS progress in Sierra Leone.

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

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion 2010. On purpose this section will be mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

2.1 HSS proposal design

Sierra Leone is one of the world's poorest countries. According to the latest UNDP Human Development Index (2006) it was ranked at 179th, the bottom position. It has some of the lowest indices for maternal and child health in the world. The maternal mortality rate was estimated at 1800/100,000 live birth in 2007². A Sierra Leonian woman faces a 1 in 6 lifetime risk of dying from a pregnancy or childbirth related condition. For every woman who dies, it is calculated that another 15-30 women will face long-term health complications. The under 5 mortality rate was estimated at 262 with more than 1 in every 5 children dying before reaching their fifth birthday¹.

It is clear the Sierra Leone is facing a massive health crisis in the aftermath of its brutal armed conflict which lasted for 10 years and which ended at the beginning of 2002. Over that period GDP per capita halved leaving more than 70 percent³ of the population living below the poverty line. Poverty is compounded by the very skewed distribution income and by the high incidence of typhoid, malaria and other communicable disease such as tuberculosis.

The focus of Sierra Leone's GAVI HSS proposal is on addressing health issues related to women and children. A number of key bottlenecks in the health system were identified that must be tackled if the health situation is to improve. These bottlenecks included:

- A large proportion of the population does not have adequate access to priority health care.
- Very few health facilities provide Basic Emergency Obstetric Care (B-EmOC).
- Majority of the Peripheral Health Unit (PHU) staff are not trained in the Integrated Management of Childhood Illnesses (IMCI).

² UNICEF

³ World Bank - Sierra Leone at a Glance

- Inadequate means of transportation for prompt referrals of severe and complicated cases.
- Irregular supervision of PHU staff, one of the causes of poor quality care.

Activities to be funded by GAVI HSS support in Sierra Leone are included in the Table 1 below.

Table 1 GAVI HSS Interventions & Budget

Area for support	Year 1	Year 2	TOTAL COST
	2008	2009	
Activity costs			
Objective 1. To increase access to essential health care services from 70% in 2006 to 90% by 2010.			
Activity 1.1 Provision of out-reach allowances for CHC staff	61,960	61,960	123,920
Activity 1.2 Procurement of motor-bikes and accessories for PHU Staff	140,000	140,000	280,000
Objective 2: To increase the proportion of peripheral health centres with staff trained in IMCI from 0% in 2006 to 90% in 2010 and those trained in B-EmOC from 20% in 2006 to 95% in 2010.			
Activity 2.1: Training of 26 Trainers in IMCI	15,600	-	
Activity 2.2: Provision of in-service training to 900 Peripheral health care staff in IMCI	70,000	100,000	170,000
Activity 2.3 Training of 26 trainers in B-EmOC	-	7,800	7,800
Activity 2.4: Provision of in-service training to 900 Peripheral health care staff in B-EMOC	100,000	70,000	170,000
Activity 2.5 : Integration of IMCI and B-EmOC into the curriculum of health care staff	15,000	15,000	30,000
Objective 3: To increase the proportion of deliveries done through caesarean section from 0.5% in 2007 to 5% in 2010.			
Activity 3.1: Provision of ambulances to districts for transportation of referral cases.	226,000	226,000	452,000
Activity 3.2: Provision of fuel for ambulances.	90,000	150,000	240,000
Activity 3.3: Provision of fuel for hospital generator for performing emergency caesarean section operation.	48,000	48,000	96,000

Objective 4: To increase the proportion of health facilities that received regular quarterly supervision from 22% in 2006 to 75% in 2010.			
Activity 4.1: Provision of transportation for monitoring and supervision of district and PHU activities.	126,000		126,000
Activity 4.2: Provision of allowances for supervision.	156,000	156,000	312,000
Activity 4.3: Provision of supervision allowance for National Staff	40,000	40,000	80,000
Support costs			
Management costs	15,000	16,500	31,500
Audit	6,000	6,000	12,000
M&E support costs	44,000	24,000	68,000
Technical support	0	0	0
TOTAL COSTS	1,153,560	1,061,260	2,214,820

Source: GAVI HSS Application

The proposal design includes objectives that addressed each of the five identified barriers to delivering high quality health care. Proposal design is very much focused on helping the country to make progress towards the achievement of the Millennium Development Goals (MDGs) 4, 5, and 6.

The main objectives of the GAVI HSS proposal are to underpin the implementation of the NHP through supporting the achievement of the following objectives:

1. To increase the proportion of planned out-reach activities conducted by Community Health Centre Staff from 32% in 2006 to 70% by 2009.
2. To increase the number of staff trained in IMCI and B-EmOC from 0 in 2007 to 200 in 2009.
3. To increase the number of deliveries done through caesarean section from 450 in 2006, to 4000 in 2009.
4. To increase the proportion of health facilities that received regular quarterly supervision from 33% in 2007 to 90% in 2009.

Use of GAVI HSS Funding

The GAVI HSS funding has been programmed to implement activities intended to support the achievement of the four main objectives outlined above. Given the acute lack of resources of all kinds in the sector, there can be a high degree of confidence that GAVI HSS funds represent necessary and additional resources for the sector.

Expenditure to-date has been minimal. Given that funds were only received in September 2008, the MoH did not have much time to get things underway before the end of 2008.

2.2 HSS application and approval processes

The proposal was developed through a consultative process involving the Ministry of Health and Sanitation, National and International Non-Governmental organisations, Civil Society Groups, Donors and UN Agencies.

The Ministry of Health designated its Department of Planning and Information (DPI) to lead the proposal preparation process. The WHO played an important role in the decision to apply for GAVI HSS support. The Director of DPI, as Team Leader, put a group together to develop the proposal. Other members of the team included: WHO, UNICEF, NGOs, Representatives of the DHMTs, and selected vertical programmes.

In February 2007 the team spent about a week in one of the health districts preparing the first draft of the proposal. Following this meeting, representatives from the Directorate of Planning and Information, EPI, and WHO participated in a GAVI HSS proposal writing workshop in Ouagadougou, Burkina Faso.

After the Ouagadougou meeting, the writing team reviewed their draft proposal in order to address bottlenecks in the health delivery system and establish priorities for GAVI HSS support. The proposal was designed to be in line with the MOHS planning cycle, which is a 3-year rolling plan and which expires in 2009. That is why the application was made only for 2008 & 2009 – to ensure alignment with the National Health Plan.

Box 1. Key dates in the Sierra Leone HSS proposal

Sep 2006	Original HSS proposal submission – approved with conditions
Feb 2007	First draft of revised GAVI HSS proposal
Mar 2007	GAVI HSS proposal writing workshop in Ouagadougou
Apr 2007	Consultations with stakeholders
May 2007	GAVI HSS proposal endorsed by Health Task Force
5 th Oct 2007	HSS Revised Proposal submitted to GAVI
7 th Nov 2007	IRC approval
28 th Nov 2007	Approval decision by GAVI Board
4 th Sept 2008	First disbursement received \$1,154,000 (delays in receiving correct bank details)
May 2009	APR with HSS section submitted by Sierra Leone

No external TA was involved. The team did not request for the \$50,000 earmarked for this purpose. They thought it unnecessary since they had sufficient capacity in-country to write the proposal.

2.3 HSS Start up measures

There was a delay of 9 months between the approval of the HSS grant by the GAVI board (28th November 2007) and the receipt of the first disbursement of funds (4th September 2008). This was due to problems in the GAVI Secretariat receiving the correct banking details for the MoH. Given that the first tranche of GAVI HSS funding did not arrive until September 2008 it is not surprising that little implementation took place during the four remaining months of 2008.

The initial set of activities that were supported were supervision and provision of out-reach services. All districts received funds for quarterly supervision, to ensure that at least 90% of health care facilities are visited each quarter. Reports received at the end of 2008 indicated that most of the districts visited at least 80% of health facilities within the period October to December 2008. About 75% of planned out-reach services were conducted by CHC staff. Staff at National level visited seven district teams to provision technical and management support.

The MoH has encountered a number of difficulties since the first tranche of GAVI HSS funds were received in September 2008. The Health Task force, the committee for overseeing the implementation of the GAVI HSS activities, underwent a reorganisation and has now become the Health Implementing Partners Coordinating Committee (HIPCC).

During the reorganisation, meetings of the group were suspended for about 4 months and began again in February 2009. During this period it was not possible to meet with the committee, so most of the decisions were taken by the Top Management Team of the Ministry of Health. However, reports of updates on GAVI HSS implementation have been forwarded to the HIPCC.

Bids received from private contractors for the procurement of goods were generally much higher than the allocated budget and in most cases, were higher than the market price. UNICEF was asked to undertake a number of procurements in order to be able to avoid problems.

Towards the end of 2008, several District Medical Officers and Hospital Medical Superintendents were transferred to new posts. These transfers have delayed the implementation of activities.

A major programmatic change that has been proposed by the members of the Health Implementing Partners Coordinating Committee (HIPCC) is that instead of buying fuel for generators for the hospitals, solar power lighting should be installed in the district hospitals. This is believed to be more sustainable and cost effective. Tenders have already been developed to support this activity. The cost of installing solar powered lighting in 15 hospitals is estimated to be about the same as providing generator fuel.

2.4 Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of Sierra Leone's established health reporting and accountability mechanisms.

The general standard of the 2008 APR is quite good, although for reasons discussed previously there is little to report on in terms of real progress against objectives.

No special indicators have been developed for the monitoring of GAVI HSS. The indicators used have all been drawn from the existing National HMIS. GAVI resources are being used to improve on data quality of the existing indicators and not to set up a parallel monitoring system⁴.

⁴ Interview with Dr. Magbity, M&E Specialist, Directorate of Planning and Information, Ministry of Health and Sanitation

Routine Health Data collection in Sierra Leone is conducted through a network of some 1000 peripheral health units and 39 hospitals that are distributed throughout the country. PHUs are expected to send their monthly reports to the District level for consolidation by the second week of each month. However majority of PHUs either never report or send their reports very late.

Effective coordination of health information is often lacking, resulting in duplication and gaps in data collection, reporting, use and management of data. Consequently, vast amounts of data collected remain mostly incomplete, unreliable and unused. Moreover, indicators are poorly harmonized with those applied elsewhere and thus difficult to use for inter-country comparisons.

Several other partners are supporting the strengthening of collection of health data. The Health Metrics Network (HMN) is supporting the strengthening of the National Health Information Systems (HIS). HMN support is primarily for conducting assessments of the National and District HIS and vital registration system and the development of an improvement plan⁵.

Financial Reporting

The APR provided a comprehensive description of the few activities that had been undertaken in the four months since the initial HSS funding was received and it included detailed reporting of expenditure against each activity.

Result indicators

The GAVI HSS proposal contained six outcome/impact indicators – see Table 3. below. Given the nature of the interventions being supported by GAVI HSS, this set of indicators is sensible and should properly reflect progress made as a result of HSS funding.

⁵ Sierra Leone, GAVI HSS Application

Table 3 Outcome & Impact Indicators

Indicator
1. National DPT/Penta3 coverage (%)
2. Number of districts achieving $\geq 80\%$ DTP3 coverage
3. Under five mortality rate (per 1000)
4. Births attended by skilled health personnel (%)
5. Deliveries conducted through caesarean section (%).
6. Underweight prevalence rate (%).

Similarly, the six output indicators selected should reasonably reflect the progress being made in implementing the HSS programme. The output indicators are listed below in Table 4 below. The only objective not really well measured by the output indicators is the provision of transport (ambulances) to improve EMOC.

Table 4 Output Indicators

Objective	Indicator
Objective 4: To increase the proportion of health facilities that received regular quarterly supervision from 22% in 2006 to 75% in 2010.	1. % of health centres visited at least 4 times in the last year using a quantified checklist
	2. Health Facilities without any stock outs of ACT, SP, measles vaccine, ORS and cotrimoxazole in last 3 months (%)
Objective 2. To increase the number of staff trained in IMCI and B-EMOC from 0 in 2007 to 200 in 2009.	3. Number of CHC staff trained in IMCI and B-EMOC
Objective 1. To increase the proportion of planned out-reach activities conducted by Community Health Centre Staff from 32% in 2006 to 70% by 2009.	4. Under-fives sleeping under ITNs (%).
	5. % of planned out-reach services conducted by CHC staff
	6. Contraceptive prevalence rate (%)

NB: Output 3 is concerned with the provision of transport to improve EMOC

There was reasonably detailed reporting against all of the result indicators included in the original HSS proposal where some activity had taken place in the four months that remained

of 2008 for the implementation of HSS activities. With the exception of “number of CHC staff trained in IMCI and B-EmOC” and “Under-fives sleeping under ITNs (%)” the 2008 APR recorded significant progress against all of the six output indicators suggesting one of two possible reasons: 1) alternative means of achieving progress against these objectives had become available: or 2) the quality of health information available was very poor.

There is little doubt that the requirements for developing an annual performance report to GAVI puts considerable additional pressure on the MoH as it does in most countries. Given the very poor state of health in Sierra Leone, it would seem sensible to look at ways in which the reporting requirements of individual funding agencies such as GAVI could be minimised in order to enable the senior management team within the MoH to focus on the quality and delivery of health services.

2.5 HSS progress to date

HSS activities had a slow start in 2008. The APR indicated that only \$US 64,490 had been spent between September and December 2008. Given the nine months delay in getting the banking details sorted out and the slow rate of spending when funds were finally received in September 2008 it might be concluded that Sierra Leone is having some difficulty in absorbing the increased volumes of funding.

2.6 End of HSS Assessment

It is hard to predict how successful the HSS work will be in Sierra Leone. Given the current low health status and very poor performance of the health system, there is a great deal of room for improvement. However, there are significant barriers, including a lack of capacity at all levels of the system combined with high levels of corruption. Clearly, progress is not going to be made easily and there will be a great need for the MoH to be effectively supported during the HSS implementation process. It is not obvious where the support is going to come from and this is a major weakness of the HSS approach. In other HSS evaluation countries the inability of WHO and UNICEF to provide sustained support to the process beyond some TA at the design and reporting stages has been very marked.

The improvements in immunisation coverage at the end of the HSS grant are likely to be modest given that there were reasonably high immunisation coverage rates in Sierra Leone at the time of proposal design. However, as the HSS funding is being invested in developing

capabilities across the system, significant improvements in the effectiveness of the health system could be anticipated.

The current HSS interventions in Sierra Leone are being implemented across the country and whilst there is a thematic focus there is no geographic one. The results will show if it may have been better to concentrate the resources in a particular geographic area rather than attempting to cover the entire country.

2.7 Support systems for GAVI HSS

The Ministry of Health designated the Department of Planning and Information as the focus for preparing the proposal. The Director of the department, as Team Leader, put a team together to develop the proposal. Other members of the team included: WHO, UNICEF, NGOs, Representatives of the DHMT, selected Programmes i.e. EPI, Malaria. The WHO played an important role in the decision to apply for GAVI HSS support. In terms of on-going support to the implementation of the HSS programme it is unclear as to the role played by WHO and other partners in this process.

3 Alignment of HSS with GAVI principles

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

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equitable

3.1 Country Driven

Whilst the WHO played a key role in the decision to apply for GAVI HSS funding the MoH was responsible for leading the design process and ensuring the effective participation of its various partners in the process.

3.2 Is GAVI HSS aligned?

In this section we consider several dimensions of alignment as discussed in the evaluation study guidelines: alignment with broader development policies such as the PRSP and the national health plans and priorities; alignment with planning and reporting systems; alignment with budget and financial management systems.

3.2.1 Alignment with broader development and health policies

The GAVI proposal is fully aligned with the priorities identified in the National Health Plan and with Sierra Leone's PRS which formed the basis for the NHP.

3.2.2 Alignment with budget and reporting cycles

Sierra Leone's financial year runs from January – December enabling alignment with the GAVI planning and budget cycles. In terms of alignment with budget and financial management procedures GAVI HSS resources are "on plan" but it is not clear if they are also "on budget".

3.3 Is GAVI HSS Harmonised?

GAVI HSS funding is being used to support the implementation of the NHP. In that sense it can be said to be fully aligned with national plans. However, the GAVI HSS funds are managed and reported on separately and have their own bank account which is operated by the MoH. The GAVI HSS programme does use the existing MoH Health Information System for reporting purposes although the GAVI APR report is developed separately. This must be a time consuming process in a MoH that is hard pressed for human resources.

3.4 Is GAVI HSS funding predictable?

Table 2 GAVI HSS Funds: Receipts and Disbursal

	Year	
	2008	2009
Amount of Funds Approved (\$US)	1,153,560	1,061,260
Date the Funds Arrived	17 th September 2008	
Amount Spent (\$US)	64,490	
Balance (\$US)	1,089,070	
Amount Requested (\$US)		

Source: 2009 GAVI APR

As previously mentioned, there was a significant nine month delay between HSS funding being approved and it being received in-country. This was apparently due to confusion over the MoH's bank account details provided to the GAVI Secretariat.

3.5 Is GAVI HSS accountable, inclusive and collaborative?

The Director of DPI, as Team Leader, put a group together to develop the proposal. Other members of the team included: WHO, UNICEF, NGOs, Representatives of the District Health Management Teams, and selected vertical programmes.

The proposal was reviewed by all members of the HTF, UN Agencies and DFID and World Bank staff working on the Reproductive and Child Health programme. The proposal development committee met on three occasions to conduct a comprehensive review of the proposal. By pooling the combined ideas from team members, some with extensive experience in working in Sierra Leone and in other developing countries, the team was able to come up with a package of activities that would best address some of the most critical needs of the sector. The team developed a draft proposal to address the prioritised barriers.

In April 2007 the revised draft proposal was circulated to all members of the Health Task Force for comments and improvement. The revised draft proposal was endorsed at the May HTF meeting.

All Members of the Health Task Force, WHO Representative, UNICEF Representative, the World Bank Task Team Leader for the RCH, the DFID Regional Health Adviser for RCH, the Minister of Health and Sanitation and the Minister of Finance endorsed the proposal.

All of the foregoing demonstrates the commitment of the MoH to making the GAVI HSS programme as collaborative and accountable as possible. However, the real challenges will come during implementation where maintaining the commitment and input of partners will become more difficult.

3.6 Does GAVI HSS have a catalytic effect?

It is Difficult to determine at this very early stage of implementation.

3.7 Is GAVI HSS Results Oriented?

The main focus of the GAVI HSS funding in Sierra Leone is on the training of a large cadre of health workers in IMCI and B-EmOC and then on ensuring that there are adequate resources available for transport, outreach and supervision. In this sense, the GAVI HSS resources can be described as very results orientated. The MoH has developed a good monitoring and results framework which should adequately reflect progress that is achieved.

The challenge will be in the effective implementation of the programme and the accurate reporting of progress made. Given the acknowledged weaknesses of the health information system this may prove to be a complex task. However, the good quality of the 2008 APR is some indication that the MoH and its partners are prepared to invest sufficient resources in programme reporting.

3.8 GAVI HSS sustainability issues

Sierra Leone is one of the world's poorest countries. There is much to be done in order to build an effective and sustainable economy and health system. Realistically, the MoH is going to require significant donor support for many years to come.

Much of the GAVI HSS support is for the purchase of vehicles and the payment of allowances. The MoH is unlikely to be able to assume financial responsibility for these costs in the foreseeable future.

Significant amounts of the GAVI HSS funding is being spent on training in areas essential to the effective operation of any health system. The focus on supporting cost-effective, evidence based interventions related to IMCI and B-EmOC will contribute to the long-term sustainability of the GAVI HSS investment.

Vehicle purchases represent a significant amount of the GAVI HSS funds. These have

associated running costs, a limited lifespan and will need to be replaced at some time.

The GAVI HSS activities are likely to have a substantial impact on the performance of the health system. If GAVI funding were to be withdrawn, this would have a serious impact on a number of these activities unless and until alternative sources of funding could be identified.

3.9 Does HSS funding help improved equity

The GAVI HSS proposal does not have a specific poverty or equity focus. Given the huge unmet health needs across the country, the high levels of poverty and the extremely unequal distribution of incomes it could easily be argued that a poverty focus is not necessary. Most people in most places in Sierra Leone will be poor and in need of effective healthcare. The emphasis on strengthening IMCI and B-EMOC should help to ensure that the poorest and least served populations in Sierra Leone benefit from the HSS funding.

Annex 1 List of people interviewed

Dr. Fussum WHO Sierra Leone

Dr. Magbity M&E Specialist, Directorate of Planning and Information, Ministry of Health

Annex 2 List of Documents reviewed

Sierra Leone, GAVI HSS Proposal

Sierra Leone, GAVI 2008 APR

National Health Policy, 1992

Poverty Reduction Strategy Paper, 2005

IMF, Poverty Reduction and Growth Facility Review, 2009

Annex 3 Summary GAVI HSS Evaluation Approach

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

There are five main objectives and areas of evaluation:

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

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

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

Annex 4 Typology of areas for HSS support.

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA (\$50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	<i>Internal process</i>	IRC-HSS
IRC recommendations	<i>Internal process</i>	IRC-HSS
Decision on proposals	<i>Internal process</i>	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring