



## GAVI support for health system strengthening

## Good examples from country proposals





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# Executive summary

This document describes a selection of country applications for GAVI Alliance health system strengthening (HSS) support. These applications have been singled out by GAVI's Independent Review Committee (IRC), which reviews all proposals from countries eligible for this type of funding, as being particularly good examples of HSS proposal development. There is a wealth of ideas contained in these HSS applications, not just in terms of how to allocate funds, but also in terms of what to focus the funds on, and how to direct funds to those areas most in need. The examples that are summarised in this document are intended to serve as a source of inspiration to those countries that are in the process of developing their own proposals, and also to their development partners who support them in so doing.

Countries started applying for GAVI's new funds for health system strengthening in November 2006. In the intervening period up to June 2008, 51 of 72 eligible countries submitted proposals, 40 of which were approved.

This corresponds to a multi-year, predictable investment of close to US\$ 500 million to strengthen health systems in these countries. GAVI HSS support is intended to help fund countries' own health and immunisation plans. The aim is to build on existing initiatives that have been proved to work and to learn from these. Thus to qualify for HSS support, countries must demonstrate that their proposal is in line with existing planning and budgeting frameworks for health system strengthening and that the planned activities will ultimately lead to sustained increased immunisation coverage. The current level of demand shows that GAVI's HSS support represents a very welcome funding opportunity for countries, and a number of proposals have articulated the need for such flexible, system-wide support.

The design of HSS funding helps countries to move towards broader, more integrated health plans and systems and encourages the active involvement of a wide range of stakeholders in the planning process. This approach supports implementation of the Paris Principles of Aid Effectiveness. The IRC has noted that,

increasingly, HSS proposals are being developed in close consultation with multilateral, bilateral and civil society partners at the country level. Closer collaboration helps not only to foster a greater sense of ownership, but also improves the quality of the proposal which, in turn, increases the likelihood of approval and the chances of implementation. A recent review of GAVI-HSS proposals<sup>1</sup> demonstrated a positive correlation between the level of collaboration during proposal development, and the likelihood that the proposal will be approved.

GAVI HSS funds are meant to be catalysts for change, supporting innovative approaches where appropriate but with the proviso that they are aligned with country priorities and harmonised with efforts of the health ministries and development partners. GAVI HSS support cannot – is not meant to – support “everything”.

Thus each proposal must provide an overview of total level of support for the health sector, showing how and where GAVI HSS funding fits in. Some of the proposals selected for inclusion in this document have been chosen because they clearly show which part of the health system and which geographical areas will be targeted with HSS funds and why.

Although, overall, the quality of GAVI-HSS applications has improved, the IRC has identified a number of weaknesses that are common to many country proposals. The main areas for further improvement are:

- **Prioritisation of identified bottlenecks and proposed activities:** HSS funding should not be used to try to address all system barriers. Rather, countries are encouraged to identify and strategically prioritise a limited number of system-related barriers that most impact the immunisation programme and to focus HSS funds on addressing these needs. HSS proposals must also be realistic; in-country partner involvement is key to ensuring that proposals meet this criterion.

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<sup>1</sup> *Country initiatives to lift health system constraints. Lessons from 49 GAVI-HSS proposals.* Geneva, WHO/UNICEF/GAVI Alliance, 2008 (WHO/HDS/HGS/2008.1).

- **Demonstrating how GAVI HSS funds will complement existing funding:** Although most countries identify the gaps in their health system well, it is not always clear from the proposals how GAVI HSS funds will complement other available funding. Inclusion of a short description of activities supported by other donors (and of their relationship to activities proposed for GAVI support) would help to clarify the situation with respect to additional funding sources.
- **Balancing health system strengthening and immunisation:** Striking the right balance between the needs of the health system in general and immunisation programmes in particular has been a challenge for a number of countries. Nevertheless, this is a requirement for HSS support, and the HSS guidelines ask countries to propose improvements to their overall health system, which will at the same time impact and improve the provision of immunisation services.
- **Sustainability of proposed activities:** Addressing sustainability is always problematic. In drawing up their proposals, countries are advised to provide evidence of funds from domestic resources, to demonstrate how efficiency will be improved and, ideally, to show how demand for services will be increased. All of these of these can contribute to sustainability.
- **Measuring impact:** Identifying appropriate indicators to monitor and evaluate the proposed activities has proved to be challenging for many countries. Proposals need to have measurable process, impact and/or outcome indicators, with clear baselines and targets, which are linked to the identified system barriers that the proposed activities are seeking to address. Attribution of the GAVI HSS investment will also continue to prove challenging.

# GAVI health system strengthening

The GAVI Alliance was launched in early 2000. Its mission – to save children’s lives and protect people’s health through increased access to immunisation. A few years on, despite having successfully increased support for immunisation programmes, it became evident that large numbers of children were still not being reached. A study commissioned by the GAVI Secretariat and led by the Norwegian Agency for Development Cooperation (NORAD) showed that health system issues beyond the immunisation system were constraining efforts to increase or maintain high immunisation coverage in the majority of developing countries. Barriers typically included unpredictable funding for salaries, transport and outreach; shortages of adequately trained human resources at all levels; and weak management at peripheral levels. It became increasingly evident that without strong underlying health systems in place, reaching and sustaining high immunisation coverage rates in all countries would be difficult.

Recognising this need, the GAVI Board in late 2005, approved an initial investment for health systems strengthening (HSS). Building on the Board decision and background documents, a set of guidelines for country proposals for

HSS funds were then developed. Fundamental to these guidelines are 10 principles; these dictate that to qualify for approval, proposals for HSS support must demonstrate that they are country-driven, country-aligned, harmonised, predictable, additional, inclusive and collaborative, catalytic, innovative, results-oriented, and sustainability-conscious.

The HSS funding window has been designed using the best practice principles on harmonisation and alignment for global health partnerships, which have recently been developed for the High-Level Forum on the Health Millennium Development Goals (MDGs)<sup>2</sup>. Just as the international organisations are working to harmonise policies and streamline systems and funding, the GAVI HSS funds provide an opportunity for countries to harmonise their policies and streamline their systems and investments in health infrastructure, including at the provincial and district levels. Some countries have commented that the HSS application process has encouraged them to look, in many cases for the first time, at their whole health system and to reflect on how best to fit the pieces together in order to make the system more effective. In some countries, the process has also provided unique opportunities for immunisation-focused staff to work with general health system planners.

<sup>2</sup> For more on the High-Level Forum on the Health Millennium Development Goals, see <http://www.hlfhealthmdgs.org/>.



All proposals received by the GAVI Secretariat are reviewed by the Independent Review Committee (IRC). This body of multi-skilled experts is constituted to review proposals thoroughly and make recommendations for funding to the GAVI Alliance Board. When reviewing requests for HSS support, the IRC is guided by a set of criteria<sup>3</sup> or a “checklist” of proposal requirements; this checklist is as follows:

- ✓ The HSS proposal development process has been inclusive, and has involved all major stakeholders.
- ✓ The application is based on recent immunisation and health sector analyses.
- ✓ The application is aligned with national policy and planning frameworks.
- ✓ It adds value to, or complements, current or planned health system strengthening activities.
- ✓ The proposed strategy is appropriate and addresses priority “bottlenecks” or barriers that impede the achievement of immunisation and other child and maternal health outcomes.
- ✓ The activities can be implemented in the suggested time frame and in a sustainable manner.

- ✓ The application adequately addresses how progress towards goals will be monitored.
- ✓ The financing plan is robust and well aligned with national health system financing plans.
- ✓ The application makes a compelling case for GAVI HSS investment.

A representative selection of good examples of country HSS proposals are described in the remainder of this document. These examples are grouped according to the above-mentioned principles that are listed in the HSS guidelines, and in each case those aspects of the proposal that demonstrate good practice in terms of a particular principle are highlighted. The selection reflects the comments made by the IRC during the course of its evaluations of HSS proposals, as well as the views of partners in the HSS Task Team.

Note that one principle, predictability, is not represented. The principle of predictability applies to the GAVI Alliance in that GAVI commits to providing predictable funding for the

<sup>3</sup> The checklist of proposal requirements is included in the HSS proposal development guidelines, which are available from the GAVI web site at <http://www.gavialliance.org/support/how/guidelines/index.php>.

duration of a country's national health sector plan (or equivalent), enabling countries to plan for the long term. The maximum amount a country can apply for at US\$ 2.50 per newborn per year or US\$ 5 per newborn per year depending on the country's per capita gross national income (GNI)<sup>4</sup>. The annual commitment from GAVI ensures countries have the opportunity to receive predictable financing and that their HSS applications match up with their multi-year planning cycles. As this principle does not lend itself to identification of good examples identified in the countries' proposals, it is not included in the following selection of good examples.

The Independent Review Committee has also identified sound financial management and monitoring as an important factor in proposal review. While this is not an HSS principle as such, it has been included at the end as a key factor for proposal success.

The full texts of all GAVI Board-approved country proposals are available via the GAVI web site<sup>5</sup>. It should be noted that the examples given represent good practice in proposal development only, and do not reflect on countries' experience in actual implementation.

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<sup>4</sup> The countries that have a per capita GNI of less than US\$ 360 per year in 2006 and therefore qualify for HSS support equivalent to US\$ 5 per newborn per year are Central African Republic, United Republic of Tanzania, Togo, Zimbabwe, Nepal, Mozambique, Uganda, The Gambia, Madagascar, Niger, Rwanda, Sierra Leone, Malawi, Eritrea, Guinea-Bissau, Ethiopia, Democratic Republic of the Congo, Liberia, Burundi, Afghanistan, Democratic People's Republic of Korea and Somalia. All other countries eligible for GAVI support can apply for up to US\$ 2.50 per newborn per year.

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<sup>5</sup> <http://www.gavialliance.org>



**Good examples from  
country proposals**

# Country-driven

*A key principle for GAVI HSS support is that it be country-driven. This means that as part of their HSS proposal development process, countries should identify their system-related bottlenecks to increased immunisation, and then determine how best to allocate funds to address these bottlenecks. Countries are encouraged to use recent immunisation programme and health sector analyses, national health sector plans (or equivalent) and other documents to identify critical areas for GAVI HSS support, prioritise these areas, and then target gaps in current funding. Ideally, proposals should identify and prioritise those health system bottlenecks and obstacles that have the greatest impact at the service-delivery level.*

*The HSS guidelines encourage countries to focus on three non-exclusive areas of work in their proposals for GAVI HSS support:*

- (i) health workforce mobilisation, distribution and motivation;*
- (ii) organisation and management of health services;*
- (iii) supply, distribution and maintenance systems for drugs, equipment and infrastructure.*

*However, if a country identifies other health system bottlenecks that are key barriers to increasing immunisation coverage, then these too can be part of the proposal.*

*In reviewing HSS proposals, the IRC has found that while applicants are generally successful in defining health system problems and bottlenecks to increased system performance, they are less successful when it comes to articulating how addressing the identified health system problems will lead to improved immunisation coverage. There is a tendency to attempt to tackle all the identified problems at once, instead of targeting GAVI funds in a more strategically-focused manner. A second shortcoming noted by the IRC is the lack of, in some countries, an appropriate health sector or other system-wide plan to link the HSS proposal to. As alignment with a country's planning framework is at the heart of HSS support, countries must have a national health plan in place before HSS funding can be approved.*

## **COUNTRY EXAMPLES**

### *Armenia*

#### **Clear links between identified problems, proposal objectives and activities**

The Armenian health system is currently in transition, moving from its former Soviet-style, resource-intensive and hospital-based foundations towards an approach that emphasises integrated service provision, as well as prevention. The Ministry of Health's new Mother and Child Health (MCH) strategy is evolving along these lines and is focusing on the need to ensure full immunisation coverage, improving antenatal and obstetric care, and improving the nutritional status of women and children.

*Barriers*

Insufficient knowledge and skills of providers

Lack of physical access in remote areas

Lack of appropriate delivery system for PHC supplies

Inadequate supportive supervision of PHC/PH services

Weak surveillance systems for communicable diseases

*Objectives/components*

Health workforce development

Establishment of integrated supportive supervision of PHC/PH services

Improving access to PHC/PH services in remote rural areas

Strengthen surveillance of communicable diseases

*Intermediate objectives*

Improved knowledge and skills of PHC/PH providers

Improved quality of PHC/PH services

Effective linkages between PHC/PH services

*Goal*

To improve quality and responsiveness of PHC/PH services, with special attention to population groups living in remote and border areas

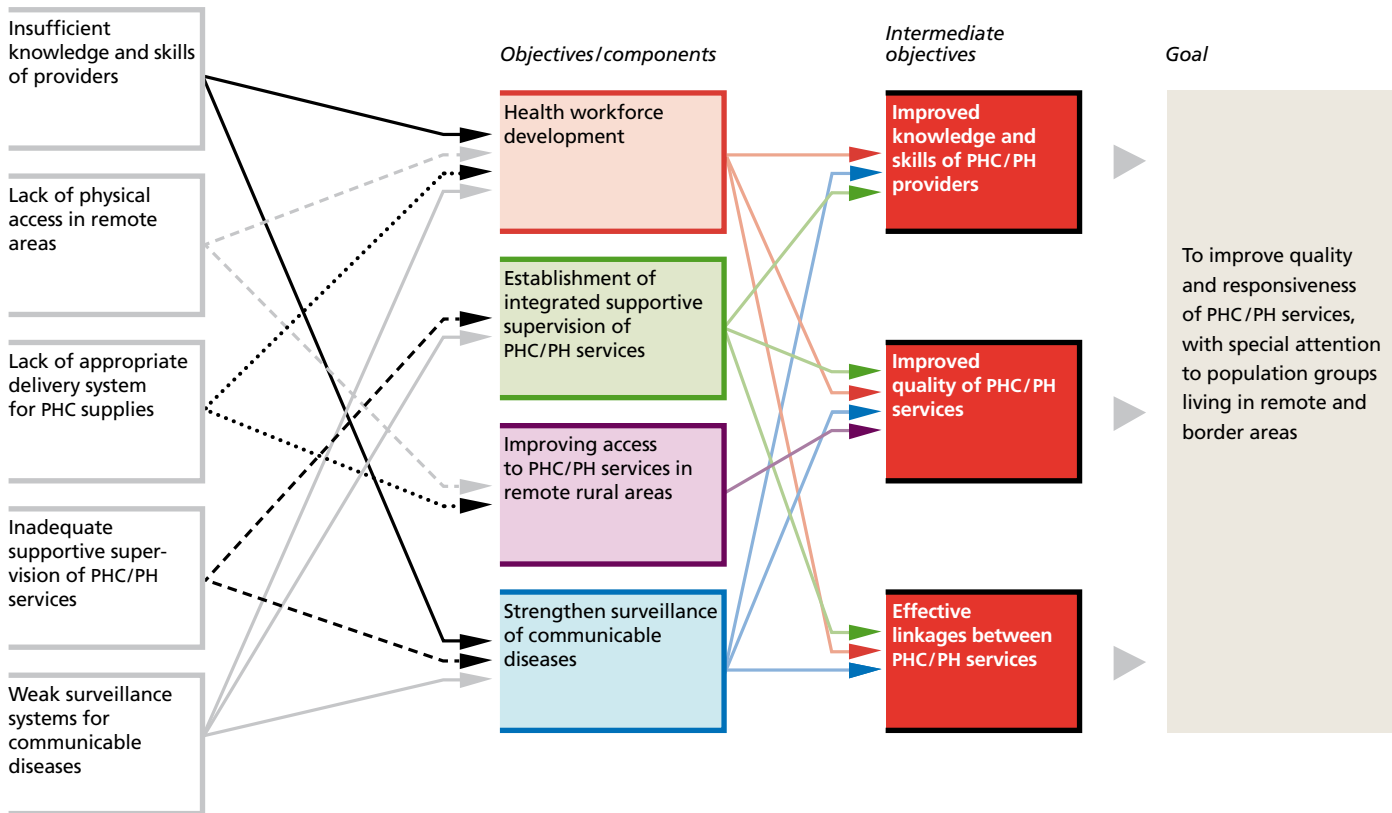


FIGURE 1

PHC/PH = primary health care/public health

Armenia's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Armenia\\_HSS\\_2008.pdf](http://www.gavialliance.org/resources/Armenia_HSS_2008.pdf)

Strengthening of primary health care services and a significant increase in public health expenditure are put forward as the main instruments for achieving these objectives.

In its HSS proposal, Armenia provides clear linkages between identified problems, the barriers that will be addressed by GAVI's HSS support, and how these barriers will be addressed. The linkages are described in a narrative, as well as in a useful chart (see Figure 1).

Armenia's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Armenia\\_HSS\\_2008.pdf](http://www.gavialliance.org/resources/Armenia_HSS_2008.pdf)

#### *Central African Republic*

#### **A geographical focus – selection of districts**

The Central African Republic faces multiple challenges to achieving its development goals. Assessments referenced in the HSS proposal show that only 22 % of the population have access to quality health care. Infant and maternal mortality have increased over the last two decades, while life expectancy has decreased. The country's latest health sector plan sets out mechanisms for identifying and addressing the barriers to reversing these trends, focusing on institutional

development, human resource availability, increased funding for health and better collaboration between partners, and considers which aspects of the plan could be implemented with GAVI support.

Having listed the main barriers identified in recent sector reviews, the Central African Republic's HSS proposal goes on to select a number of activities designed to overcome these barriers for pilot implementation, prior to nationwide roll-out of the health sector reform plan (which has been developed as part of the latest national health sector plan). The cost of implementing both delivery of the country's health-related "minimum package of activities" at the primary level, as well as the critical supportive/referral services (to be offered at the district hospital level as a "complementary package" of activities) was estimated. Realising that the per capita cost of these services was far greater than the amount of funding available (considering both the GAVI HSS entitlement and additional funding from other development partners), a number of strategically important districts were selected as targets for HSS funding.

Poor performance in immunisation was the primary criterion used for selecting districts (as a proxy measure for functionality of the district health system). Further selection was carried out based on:

- (i) physical accessibility (governs likelihood of effective logistical support and supervision); and
- (ii) the security situation (determines whether environment is conducive to implementation).

Several nongovernmental organisations (NGOs), which were part of the HSS proposal consortium, also informed the final selection of districts.

In its review of the proposal, the IRC highlighted the geographical focus, and also the methodology adopted for selecting districts to be targeted with HSS funds, and commented that this provided a good example of a country-driven process.

The full Central African Republic HSS proposal is available at:  
[http://www.gavialliance.org/resources/Proposal\\_11.doc](http://www.gavialliance.org/resources/Proposal_11.doc)

*Kenya*

### **Ensuring equitable selection of HSS-targeted districts**

According to WHO estimates, Kenya's immunisation coverage reached a high of 94 % in 1995. Coverage subsequently dropped, but is now increasing again. Current estimates put DTP<sub>3</sub> immunisation coverage at around 80 %. With GAVI support, Kenya has also successfully introduced hepatitis B and Hib vaccines as part of the 5-in-1 pentavalent vaccine, as well as a yellow fever vaccine.

Kenya's HSS proposal describes how the challenge of increasing access is not confined to immunisation services, but is rather a system-wide problem,

with the main bottlenecks to improved service coverage identified as being:

- a) absence of adequate system resource inputs to enable delivery of the defined immunisation services needed to improve coverage;
- b) inefficient utilisation of the few, available inputs;
- c) inadequacy of the common management arrangements to follow up and guide immunisation programme activities.

Given the scope of GAVI HSS support, it was decided that it would be better to concentrate resources in few strategically important districts rather than to spread resources more thinly over a wider geographical area. This approach would also help to avoid overlap with government and other development partner projects – if GAVI funds were to be channelled to selected districts, resources mobilised from other sources could be allocated to other districts. The overall impact of this synergy is described as having “a country-wide effect” that not only increases immunisation coverage but also access and utilisation of other health services.

The proposal identifies 64 districts that have both “low utilisation of available services”, and “low access to services”. Districts for HSS intervention were selected from among these 64 according to several criteria, based on access and utilisation rates in immunisation and availability of support from other

partners. The two main inclusion criteria used are as follows:

- *Number of unvaccinated children against measles:* this is the difference between surviving children and those who started vaccination (“access gain”);
- *Number of children not completing immunisation:* this is the difference between those who started the pentavalent vaccine course and those immunised against measles (“efficiency gain”).

As the districts achieved different rankings when the two criteria were used separately, the selection criteria were combined into a single measure, the “total gain”, which is the sum of the efficiency and access gains. Districts were subsequently ranked according to their potential total gain, the 22 districts with the highest potential total gain being selected for GAVI HSS support. These 22 districts account for 66 % of children that have not accessed immunisation and 49 % of those who have not completed their immunisations, or 59 % of potential total increase.

Kenya’s HSS proposal is available at:  
<http://www.gavialliance.org/resources/Proposal.doc>.

### *Nicaragua*

#### **A well coordinated proposal development process**

About half of the Nicaraguan population is classified as living in poverty, among which there will be a clustering of health problems. Drawing on recent

reviews, the HSS proposal identifies a small number of low-performing districts, for which a goal of achieving (or maintaining) immunisation coverage of at least 95 % has been set. It is envisaged that this goal will be achieved through improved health service management, in particular, better information management, improved supervision and monitoring, improved service delivery in remote areas, and greater involvement of civil society and communities.

The IRC commended Nicaragua for its well coordinated and inclusive HSS proposal development process, which involved a wide range of stakeholders thereby ensuring broad ownership. The process took place over a period of 7 months and involved consultations with technical experts from various groups both within and outside of the Ministry of Health (including NGOs, bilateral and multilateral agencies in Nicaragua), and also with individuals and representatives of local community organisations. In addition, national workshops were held, the deliberations of which were also fed into the final proposal. Of special note is the incorporation of a round of external peer review, as well as a consultation with the National Public Investment Committee. The HSS proposal development was also linked to GAVI proposal development for immunisation services strengthening (ISS) and new vaccine support (NVS).

Nicaragua’s HSS proposal is available at:  
[http://www.gavialliance.org/resources/7\\_Nicaragua\\_HSS\\_Application.pdf](http://www.gavialliance.org/resources/7_Nicaragua_HSS_Application.pdf)

# Country-aligned

*GAVI-supported health system strengthening should be consistent with the objectives, strategies and planning cycles of existing health sector policies and frameworks. Operationally, HSS support should be aligned with government management systems and financial management procedures, and be reflected in national budgets where possible. Assuming these exist, it is recommended that GAVI HSS support be part of any pooled funding arrangements, in line with the Paris Principles for Aid Effectiveness. The purpose of “country alignment” is therefore to ensure that the GAVI HSS programme is well integrated and aligned with existing funding streams, country programmes and budgets. Although certain standards of financial accountability have to be met, countries should not create new management systems or structures to implement HSS funds, and HSS-funded activities should not compete with established programmes.*

*There are many ways in which GAVI HSS support can be aligned with country processes. These include integration and alignment with existing country planning cycles and fiscal calendars; use of appropriate mechanisms (i.e. those that are best suited to the country) for channelling funds and procuring supplies or services; and use of country mechanisms for auditing and accountability purposes. Generally speaking, the HSS proposals that have been received have been satisfactorily aligned with national health system policies and plans. However, a frequent weakness noted by the IRC is a lack of integration – in terms of the management of GAVI-supported*

*projects – with other programmes within the overall health system. This has been especially noticeable in the case of procurement mechanisms. Also, some applicants had difficulty in explicitly demonstrating how the proposed activities would eventually lead to improved immunisation rates. The IRC reminds countries to keep the ultimate HSS objective in mind when developing proposals, namely, “to achieve and sustain increased immunisation coverage in all GAVI eligible countries, through strengthening the capacity of the health system to provide immunisation and other health services”.*

## COUNTRY EXAMPLES

*Georgia*

### **Assessment of possibilities for use of GAVI support**

In 1995, following a difficult period after the dissolution of the former Soviet Union, Georgia initiated an extensive health reform programme. As a result some health indicators, including overall immunisation coverage, have increased, but others, among them infant and maternal mortality, remain relatively high compared with other European countries. Building on recent assessments of the reform programme, the Government of Georgia has pledged to increase

“immunisation coverage and its sustainability through the provision of support to ongoing health reforms at the national and rayon [district] levels”. Within the framework of this overarching objective, Georgia has developed an HSS proposal which includes a detailed analysis of the various ways in which GAVI support might be utilised so as to achieve maximum effect.

In order to explore the opportunities that GAVI support offers, Georgia established a dedicated task force to debate and recommend appropriate activities, drawing on trends in health care reform and system assessment findings. The task force identified weaknesses that simultaneously impact on the performance of the health system overall and also, directly or indirectly, on immunisation coverage levels. These weaknesses were found to stem largely from inadequately developed infrastructure and human resources, particularly at the local and primary health-care provider levels. This knowledge helped to inform the delineation of activities to be included in the HSS proposal.

Georgia’s systematic analysis of the options for using HSS funds was commended by the IRC. More information can be obtained from Georgia’s HSS proposal, which is available at: [http://www.gavialliance.org/resources/Georgia\\_HSS\\_Application.pdf](http://www.gavialliance.org/resources/Georgia_HSS_Application.pdf)

### *Liberia*

#### **Good integration of proposed activities with the overall health sector plan**

Investment in health infrastructure in Liberia has been extremely low in the past, falling to “virtually zero” in 1996 according to the country’s recent HSS proposal. Although now emerging from a period of civil unrest, mortality rates among infants and the under-fives in Liberia remain one of the highest among the African countries. In 2006, and in the absence of reliable baseline data, the Ministry of Health carried out a rapid health assessment which identified gaps and weaknesses in health interventions, human resources, management structures, financing, infrastructure and stakeholder coordination. Based on the assessment’s findings and recommendations, and in consultation with stakeholders, a draft National Health Policy and a National Health and Social Welfare Plan were developed. Liberia’s proposal for GAVI HSS support contains a clear account of the development of its overall health planning framework, and demonstrates that the areas identified for GAVI support are aligned with the priorities of the National Health Policy and National Health and Social Welfare Plan, which include:

- the strengthening of primary health care services through the Basic Package of Health Services (BPHS), with child survival as an entry point to operationalise the national health plan;
- the development and implementation of clear guidelines and training plans for increasing population access to health services;



- evidence-based management (support systems) for primary health care service provision;
- human resources development for health through expansion of community-based health workers, coupled with development and use of strategies to ensure efficient performance of existing community health workers at the county level in offering an integrated BPHS.

The IRC has singled out Liberia's HSS proposal as being a model example of how to frame proposed activities within the context of an overall health sector plan. It has also commended Liberia on the inclusiveness of its proposal preparation process.

Liberia's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Liberia\\_HSS\\_Application\\_March\\_2007.doc](http://www.gavialliance.org/resources/Liberia_HSS_Application_March_2007.doc)

### *Nepal*

#### **Well presented barriers, objectives, activities and contributions of other partners**

With immunisation coverage above 90 % in 50 of the country's 75 districts, Nepal's immunisation system is already strong. The HSS proposal aims not only to extend the high immunisation rates to all districts, by targeting the hard-to-reach, vulnerable populations, but also to improve health outcomes for women and children more generally. This will be achieved by addressing the significant system barriers that are currently faced by immunisation services, and which

also constrain the delivery of essential health-care services and other maternal and child health services. The Ministry writes that, "In this way, GAVI support for HSS will contribute to a coherent and consistent effort to win long-term gains in the health status of women and children, meeting the responsibilities described in the Statement of Intent to Guide the Partnership of Health Sector Development in Nepal".

A weakness common to many HSS proposals is the lack of transparent links between programme objectives and planned activities. Some proposals fall down because they fail to prioritise the activities that will be implemented with GAVI HSS support. In its proposal to GAVI, Nepal has included a table that charts the identified barriers, the associated health plan objectives, the proposed activities for reducing the barriers and potential sources of financing, indicating whether the activity would be a priority target for GAVI support<sup>6</sup>. The IRC has commented favourably on the use of such a device as a tool to help countries articulate the linkages between objectives and activities, even going so far as to state that, "This is the type of table that all countries should be encouraged to include in their proposals."

Nepal's HSS proposal, including Table A, is available at:  
[http://www.gavialliance.org/resources/Proposal\\_2.pdf](http://www.gavialliance.org/resources/Proposal_2.pdf)

<sup>6</sup> See Table A, pages 28–30 of Nepal's HSS proposal.

# Harmonised

*Activities in HSS proposals to GAVI should add value to or complement, but not compete with, current or planned efforts to strengthen the health system by government, civil society and health sector partners. Some applicants have been more successful than others in their efforts to show how GAVI HSS funds would complement those already allocated to existing or planned programmes. A common feature of many proposals has been insufficient attention to the harmonisation of GAVI HSS support with the Global Fund for AIDS, TB and Malaria (GFATM) and other support mechanisms for health systems strengthening. To help countries overcome this potential pitfall, the current set of HSS guidelines contain an optional table (Table 8.3) which, if completed, would provide a good overview of how the HSS proposal complements current health sector processes. Some countries have provided lists of other donor funds, which the IRC states are also very useful, especially when accompanied by a short description of those funds and their relationship to activities proposed for GAVI support.*

## COUNTRY EXAMPLES

### Cambodia

#### **Link between requested GAVI support and Global Fund HSS funding**

Since the early 1990s, Cambodia has been working with partners to rebuild a health system that has suffered from the effects of three decades of war. A programme of health sector reform was mapped out in a national Health Coverage Plan and various activities and projects implemented from 1996 onwards. To strengthen the quality of health service delivery to its largely rural population, Cambodia has implemented an essential package of health services throughout the public health system. This “minimum package” comprises integrated essential activities for preventive and primary health care, and has immunisation as a key component. To deliver the services, the Ministry of Health uses innovative performance-based management agreements designed to operate at all levels, including the provincial, district and health centre levels.

A number of partners support Cambodia in its efforts to strengthen health service delivery. Cambodia’s GAVI HSS proposal is designed to complement and build upon GFATM-funded activities that are already in their implementation phase. The GFATM projects focus on capacity building to support integrated planning, monitoring and evaluation cycles at the provincial and central levels. Districts selected for GAVI HSS support will be in GFATM-supported provinces, and, according to the proposal, “synergies between projects will be strengthened through integrated monitoring and



supervision for both projects carried out by teams from public health departments, as well as through management training at the central level designed to support the MPA Management Training Module for ODs [operational health districts] and HCs [health centres]”.

Cambodia’s first HSS proposal, linked to the last year of the country’s 2003–2007 health sector plan was approved in early 2007. In June 2008, Cambodia received approval for HSS support linked to its 2008–2015 Health Sector Plan. Cambodia’s HSS proposals are available at: [http://www.gavialliance.org/performance/country\\_results/index.php?contID=6&countID=11](http://www.gavialliance.org/performance/country_results/index.php?contID=6&countID=11)

#### *Sudan*

#### **Analysis of funding gap in national health plan**

Against a backdrop of disruptive conflict, Sudan’s health indicators are poor and progress towards achieving the Millennium Development Goals is slow. Following the recent signing of a comprehensive peace agreement to end the country’s civil war, the Sudan has developed a proposal for GAVI HSS support to help strengthen health services in the 15 states of northern Sudan, which will benefit a population of about 30 million. The main objectives of the HSS proposal are stated as being:

- 1 by end of 2012, to strengthen/build core systems and capacities (organisations and management; health planning and development; health financing; health management information systems; and monitoring and evaluation) in 15 northern state ministries of health (SMOHs) and 20 localities/districts;
- 2 by end of 2012, to develop health human resources and strengthen the capacity of 11 SMOHs to produce, deploy and retain primary health care workers, focusing on nurses, midwives, laboratory technicians and multi-purpose health workers;
- 3 by end of 2012, to contribute to achieving a 90% immunisation coverage in all 15 northern states through increasing the number of fixed sites by 25%, from the current level of 1,260 facilities;
- 4 by end of 2012, to contribute to achieving 75% equitable coverage and access to quality public health services necessary for improved maternal health and child survival in four targeted states.

The HSS objectives are drawn from Sudan’s National Health Policy, which in turn is linked to health sector planning frameworks, and builds on a review of available studies of the different components of the health system and discussions with stakeholders.

In the view of the IRC, the strength of Sudan’s HSS proposal lies in its excellent analysis of the donor situation, contributions and focal areas in relation to

the national health strategy plan. It clearly highlights available resources from key development partners that are being provided to address identified barriers through specified activities, succinctly identifying the funding gap and the contribution of GAVI support in the process. The analysis is presented by type of partner (which include bilateral partners, United Nations agencies, the Health Metrics Network, GAVI ISS, the GFATM and NGOs), and in each case describes the role and contribution of individual partners. Available resources and corresponding funding gaps

for aspects of the health plan are also clearly identified. The IRC has also praised the analysis of the funding gaps, which has been conducted in such a way so as to leave no doubt about the additionality of GAVI funds.

The analysis of available resources from different sources can be found on pages 22–25 of Sudan’s HSS proposal. The full text of the proposal is available at:  
[http://www.gavialliance.org/resources/10\\_Sudan\\_HSS\\_Application.doc](http://www.gavialliance.org/resources/10_Sudan_HSS_Application.doc)

# Additional

*Funds requested from GAVI for health system strengthening should be additional to those for existing programmes. In other words, GAVI funds must not replace other resources previously allocated to the health care sector. The IRC has commented that, on the basis of information provided in some HSS proposals, it is not always possible to determine whether the GAVI funds would indeed be additional. For this reason, Table 8.3 in the HSS application form is now compulsory and must be filled in by all applicants as part of the proposal development process. A number of past proposals have, however, presented their financial information in such a way that clearly shows that the GAVI funding would be additional and complementary to existing funding; proposals that are, in the opinion of the IRC, exemplary in this regard are detailed further below.*

## COUNTRY EXAMPLES

### Ethiopia

#### **Demonstrated additionality**

In an effort to scale up health service access to its 80-million strong and dispersed population, Ethiopia is in the process of rolling out its Health Extension Programme (HEP). The HEP is the centerpiece of Ethiopia's third (and current) Health Sector Development Programme. Through the HEP, 30,000 health extension workers will be trained and deployed in 15,000 communities, providing 16 different preventive health interventions, including vaccinations. The HEP is a huge undertaking, but is well supported by a range of development partners.

The IRC has commended Ethiopia's HSS proposal for clearly demonstrating that the funding requested is additional to current funding and furthermore fits well with other plans. The IRC concluded that,

The Ethiopian Ministry of Health is rolling out the Health Service Extension Programme (HEP), which will provide basic health services to the country's 80-million strong population. HSS funds are used to plug HEP funding gaps, including the construction of health posts. Here, health extension worker Ajebush Wakalto prepares to immunise baby Brucktayet at Timbicho health post in southern Ethiopia.



UNICEF ETHIOPIA/INDRIAS GETACHEW

“The gap in funding was well-defined, sustainability was addressed, and the involvement of partners was evident”.

Ethiopia’s proposal owes much of its success in demonstrating additionality of GAVI funds to a well designed table that shows – for three different and progressive health sector scenarios – funding needs alongside available funds (from the government budget, bilateral and multilateral partners, and other GAVI funds) and the corresponding funding gaps. In its analysis of available funds, the proposal notes that only about 10% of the external resources for health are allocated to system strengthening, leaving the “generic” elements of the health system and services outside vertical disease programmes substantially under funded. The proposal then describes how GAVI HSS funds could be used to redress this imbalance.

The table in question can be found on page 37 of Ethiopia’s HSS proposal, which is available at: [http://www.gavialliance.org/resources/Ethiopia\\_HSS\\_GAVIapplication\\_feb2007.pdf](http://www.gavialliance.org/resources/Ethiopia_HSS_GAVIapplication_feb2007.pdf)

### *Madagascar*

#### **Useful table outlining contributions of other partners**

Madagascar is experiencing a period of economic growth and while still high, poverty is steadily declining, especially in rural areas. Although on the whole key health indicators are improving, immunisation coverage has remained stable at around 60% for several years.

Madagascar’s HSS proposal summarises the strengths and weaknesses of the country’s health system identified in the latest national health sector plan (*Plan de Développement Sectoriel Santé (PDSS), 2007–2011*). In order to address the identified strengths and weaknesses, five main activities have been proposed:

- (i) strengthening of quality health services for the entire population;
- (ii) improving human resource management through a sector enlargement strategy;
- (iii) mobilisation and allocation of financial resources;
- (iv) stimulating demand for, and use of, health services;
- (v) strengthening and institutionalisation of an effective monitoring and evaluation system.

The proposal also examines recent studies and analyses of the health system, identifying critical barriers and bottlenecks to increased service provision. Using a tabular format, these barriers are grouped under the five areas of activity listed above and for each, information is given about related activities, the partners involved, and whether or not additional GAVI funds will be required to address that particular barrier.

The relevant table appears on pages 18–20 of Madagascar’s HSS proposal, which is available at: [http://www.gavialliance.org/resources/proposal\\_14.doc](http://www.gavialliance.org/resources/proposal_14.doc)



# Inclusive and collaborative

*While proposals need to be country-led, the very nature of GAVI's HSS funding demands involvement of a broad spectrum of people and organisations in their development and implementation in order to increase the likelihood of success. This diversity of collaboration is essential at the global, regional and most importantly at the country level. Without "buy-in" from national and local entities, the private sector and civil society organisations (CSOs) working in the health-care system, programmes will not be effective.*

*The HSS guidelines stipulate that, "All key stakeholders in health system strengthening (beyond the immunisation programme) should be involved in GAVI 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." To this end, and as part of its review process for each proposal, the IRC examines minutes of meetings – which must be submitted with proposals for HSS support – for evidence of collaboration between partners and between different departments within government ministries.*

*Many of the early HSS applications did not involve the breadth of groups that the GAVI HSS process strives for. Furthermore, while HSS requests*

*are supposed to be handled by the planning department of a health ministry (and not by immunisation services or the Expanded Programme on Immunization (EPI) where other types of GAVI support belong), it was evident that in several of the earlier proposals the immunisation departments were very much involved. However, by the fourth round of proposal reviews, which took place in late 2007, noticeable improvements had been made in both these respects. The one remaining weakness, present in almost all of the applications, was the lack of CSO and private sector involvement. The IRC also noted that collaboration appears to be strongest in the fragile states.*

## COUNTRY EXAMPLE

### *Democratic Republic of the Congo* **Inclusive proposal development process**

In a vast and largely inaccessible country recently emerged from a devastating conflict, and with almost no infrastructure, lingering unrest and deep poverty, the Ministry of Health of the Democratic Republic of the Congo is working to provide health services in very challenging circumstances. Based on plans for health system strengthening endorsed in 2006, the Ministry hopes to halt the gradual deterioration in the country's health system by revitalising its "health zones". The health zones (which correspond to health

districts) operate under the auspices of the Ministry of Health, in cooperation with its partners, but their activities are largely implemented through NGOs. GAVI's HSS funds will target the 65 lowest-performing health zones, providing support for both central and mid-level development, in particular, for infrastructural development and human resource development.

In recent years, the Ministry of Health has strived to establish close links with its development partners in the health sector, including NGOs. The HSS proposal

development process has provided a timely opportunity to consolidate these collaborative partnerships and to re-establish the central coordinating role of the Ministry of Health. The IRC has commended the Democratic Republic of the Congo for its especially inclusive HSS proposal development process.

The Democratic Republic of the Congo's HSS proposal is available at:

[http://www.gavialliance.org/resources/Congo\\_Dem\\_Rep\\_HSS\\_Proposal\\_en.doc](http://www.gavialliance.org/resources/Congo_Dem_Rep_HSS_Proposal_en.doc)



GAVI/08/OLIVIER ASSELIN

Coming out of prolonged conflict, the Democratic Republic of the Congo will primarily spend GAVI HSS funds on rebuilding damaged health infrastructure. This health post in the remote Tshishimbi district, Kasai Oriental state, will be refurbished by the Ministry of Health in partnership with UN agencies and civil society organisations. In the photo, UNICEF health officer Bonny Sumaili, NGO Project AXxes child survival officer Joaquim Lubiba, and health zone chief medical officer Dr. Ali Kapuya survey the building.

# Catalytic and innovative

*It is not the intention, in allocating GAVI funds, to encourage new initiatives that merely “reinvent the wheel”; the aim is rather to support what is known to work. Nevertheless, GAVI HSS support is expected to be a catalytic agent for change wherever and whenever possible. In practice this could mean supporting small-scale programmes in geographically discrete areas that could subsequently be scaled up by government. It could equally well mean encouraging the development of new and innovative approaches that could be replicated elsewhere. GAVI HSS funds can therefore be used to try something completely new, to pursue a different approach to that tried in the past, or to adopt or adapt strategies that have been found to be useful in other countries.*

*The IRC has acknowledged that the HSS guidelines’ emphasis on “catalytic and innovative approaches” may have in the past contributed to a common weakness among proposals that was noted above, namely, the “tendency for some countries to describe rather grandiose objectives that really relate to the overall health sector strategy rather than finding output more closely aligned to the areas to be supported by GAVI”. This comment notwithstanding, the IRC has identified some applications that incorporate innovative approaches to very good effect. Noteworthy examples include programmes to encourage increased private-sector participation, ways to address the health of the health workers themselves, innovative non-financial award programmes for high-performing districts, and ways to increase demand for services.*

## COUNTRY EXAMPLES

*Afghanistan*

### **Public-private partnership for health care delivery**

Following two decades of war, Afghanistan has in the recent past registered some of the worst infant and mortality rates in the world. Access to health care is still extremely limited. In 2003, the government undertook sweeping health reforms, starting by defining a Basic Package of Health Services (BPHS). With support from donors and health partners, initial efforts focused on the most critical and cost-effective services, including immunisation, and how best to deliver them.



GOVERNMENT OF AFGHANISTAN

Afghanistan’s HSS proposal describes an innovative model for public-private partnership to bring basic health services and supplies to inhabitants dispersed across a vast and harsh landscape. As shown in the photo, providing vaccines and other health supplies to some remote communities requires use of donkeys across high-altitude mountain ranges.

Drawing on lessons learnt from implementing the BPHS, the Afghan HSS proposal charts the barriers to improved service delivery that have previously been identified; these include limited physical access to services, weak demand for health services, and the need to further strengthen the stewardship role of the Ministry of Public Health (MOPH) in a context where civil society partners are contracted to carry out the bulk of actual service delivery. Afghanistan intends to use its GAVI HSS funds to overcome these barriers, i.e. to improve access to quality health care, to increase demand for and utilisation of health care, to strengthen the stewardship function of the MOPH, and to increase financial sustainability.

The Afghan model of health service delivery represents an innovative example of a public–private partnership, in which development partners in collaboration with international and local CSOs manage the health service provision, using different models, to bring the BPHS to communities. Thus the bulk of GAVI’s HSS support will be spent on activities that are contracted out to CSOs, such as the establishment of mobile health teams and health sub-centres (to

improve physical access to quality health services). Funds will also be allocated to health worker training as well as to increasing demand for immunisation and maternal and child health services.

Afghanistan’s HSS proposal is available at:  
<http://www.gavialliance.org/resources/Proposal.pdf>

### *Indonesia*

#### **Piloting partnership with civil society and the private sector**

With a population of around 230 million scattered over more than 6,000 islands, Indonesia faces many challenges, but especially logistical challenges, to increasing immunisation coverage. Prior to the financial crisis of the late 1990s, Indonesia had attained high levels of routine immunisation. However, since then immunisation and health coverage have been less complete, as evidenced by recent epidemics of measles and polio. Analysis of the underlying causes of declining performance identified problems specific to the immunisation programme, as well as more systemic challenges.

Indonesia’s HSS proposal is targeted at some of the more systemic challenges that are evident in five of the country’s provinces, three populous provinces with low immunisation coverage, and two that are experiencing compound challenges, among them a lack of human resources and service infrastructure.

The HSS proposal sets out how access to services in these five provinces can be increased through the adoption of a range of approaches, several of which rely on greater involvement of CSOs. The intention is



Indonesia will use the HSS funds to pilot operational research and service provision in the provinces experiencing the largest challenges and the lowest immunisation coverage. In the photo, baby Naila Nur Fatimah is waiting to be vaccinated by Dr. Maria Umi in Pasir Kaliki district in West Java, a part of the country where immunisation coverage is high.

to contract out services such as community mobilisation and service delivery to the CSOs; in addition, private health-care providers, in particular privately-practising midwives, will receive training and information about good practice in the field of mother and child health. In another linked initiative, local universities will be contracted to carry out operational research on pilot-scale interventions to motivate the health force; in a parallel scheme, CSOs will be contracted to provide health services using its own management and personnel in a currently under-served area.

Indonesia's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Indonesia\\_HSS\\_2008.pdf](http://www.gavialliance.org/resources/Indonesia_HSS_2008.pdf)

### Myanmar

#### Operational research part of implementation and monitoring

Although some progress has been made in recent years, Myanmar is experiencing a significant communicable disease burden, and health service access, particularly in rural areas, remains poor. WHO estimates that immunisation coverage averages 82 %, but there are wide variations between urban and rural areas. The main health system barriers are categorised by Myanmar's health planners and managers as:

- (i) service delivery barriers; these are related to cultural diversity, and problems with remoteness and/or security;
- (ii) management and organisational barriers: these arise as a consequence of the current system of management of, at the township level, a range of vertical programmes, including curative focused health services, which tend to attract the great majority of health spending (WHO estimates that 90 % of health spending in Myanmar is private, out-of-pocket expenditure);
- (iii) human resource barriers: these manifest as too few health professionals, confusion of roles, and a mismatched skills base, particularly at the peripheral levels of the health system.

The goals of Myanmar's HSS proposal are closely linked to these three types of barriers. To support programme implementation and evaluation, Myanmar plans to carry out a programme of operational research. It is intended that much of

this research will be led by the departments of Planning and Medical Research (lower, central and upper Myanmar), with additional research support coming from links with the Asia-Pacific Action Alliance on Human Resources for Health and United Nations agencies. In addition, the Ministry of Health plans to establish a Health System Research Fund at the Department of Health, to assist in building and sustaining research capacity in Myanmar. Applications for funding of health systems research from national institutes will be invited on an annual basis, and technical oversight and support will be provided by the HSS Technical Working Group.

Full details of the proposed operational research programme can be found on pages 63–65 of Myanmar's proposal, which can be accessed at [http://www.gavialliance.org/resources/Myanmar\\_HSS\\_2008.pdf](http://www.gavialliance.org/resources/Myanmar_HSS_2008.pdf)

### *Uganda*

#### **Increased private sector participation**

Although Uganda's health indicators are improving, the country is still struggling with poverty and problems associated with the conflict and related insecurity issues that prevail in the northern part of the country. In fulfilment of the health sector's contribution to Uganda's poverty eradication plan and the Millennium Development Goals, the Ministry of Health is in the process of implementing its Health Sector Strategic Plan. As part of the planning process, the Ministry carried out an assessment of system barriers to immu-

nisation delivery in 2004. The main system barriers were identified as being a lack of funding, a shortage of human resources and a lack of transport at all levels. Low remuneration and under investment in pre-service training for health workers, which has led to staff shortages, were listed as being especially critical in the predominantly rural and hard-to-reach areas.

In order to address these barriers, Uganda is looking to increase private sector participation in immunisation delivery. In Uganda, the majority of people in urban areas seek health care in private facilities, yet according to one study, only 22 % of private facilities in the capital, Kampala, provide immunisation services. As noted in the HSS proposal, this represents a missed opportunity for improving immunisation service delivery. The main reason for the low private sector involvement in immunisation was found to be a lack of equipment and training.

Strengthening the capacity of the private sector to deliver immunisation and other child health services by providing cold chain and training is one of four main objectives of Uganda's HSS proposal. To this end, Uganda has proposed a mapping exercise of private clinics in Kampala and selected districts. Clinics that are willing to provide immunisation services will receive fridges and cold boxes, which will enable them not only to provide vaccines but also to serve as supply centres for other private vaccine providers. It is hoped that up to 200 clinics will join the scheme. A comprehensive assessment will be conducted after one year in order to determine the way forward with regard to provision of immunisation and other public health services by the private sector.

The planned activities will be carried out in close collaboration with professional bodies such as the Uganda Private Medical Practitioners Association and the Uganda Private Midwives Association, as well as with nurses and allied health professionals. The aim is to increase the proportion of children vaccinated in private facilities from 15 % in 2004/2005 to 50 % in 2009/2010. In linking the proposed activities to the catalytic aspect of GAVI HSS funding, Uganda's proposal states that "... the funds being applied for will act as catalytic funding and once the confidence has been built on the public-private partnership in health then the private sector will be encouraged to start implementing these activities on their own. They can as well require that all private clinics registering with professional health bodies should have facilities for them to provide immunization services and other MCH activities. This investment in infrastructure, vehicles, bicycles and tricycles is therefore worthwhile, as it will improve the health system and result into improvement of immunisation coverage" (page 38).

Uganda's HSS proposal is available at:  
[http://www.gavialliance.org/resources/14\\_Uganda\\_HSS\\_Proposal.doc](http://www.gavialliance.org/resources/14_Uganda_HSS_Proposal.doc)

## Yemen

### **Operational research provides evidence base for interventions**

Despite the challenges posed by poverty and a geographically dispersed population, Yemen's health indicators are steadily improving and immunisation coverage rates have increased to 85 %. The major health system barriers have been identified, and are listed as being difficulty in reaching a geographically dispersed population with adequate services, vertical programming that creates inefficiencies, inadequate funding, insufficient support to health workers, mismatch between health sector priorities and funding/management of the country's decentralisation strategy, weak monitoring and management systems, and in the case of women's services, cultural barriers to access.

Acknowledging these barriers, the Ministry of Health has recast its health planning framework, and is planning to make changes in the mode of service delivery, away from a system reliant on fixed-site provision to one that is based on more outreach-based provision that which integrates several currently vertical programmes. The goal of the GAVI HSS support is "to improve the performance, efficiency and reach of district health systems, through initiation of a model that integrates the resources and operations of vertical programs, that complements fixed-site health care provision with outreach, and that utilizes results-based motivational systems. The ultimate goal is to improve MDG performance nationwide in reducing child and maternal mortality, and to halt and reverse the spread of malaria and TB".

The requirement for operational research to fill knowledge gaps is a key element of the proposal. In-depth analysis of health management systems and an assessment of training needs for managers and other staff (activity 1.1) are listed among the priority areas for study, as is rapid operational research to identify both what is and what isn't working in the integrated outreach programmes. The results of the latter in particular will be used to adjust and streamline programmes, and to inform policy-making (activity 3.6).

The Yemeni proposal provides a particularly good example of how operational research can be used as a basis for developing evidence-based health system policy and implementation and is available at:  
<http://www.gavialliance.org/resources/Proposal.DOC>

### *Zambia*

#### **Non-financial rewards for high-performing districts**

In recent years, Zambia's immunisation programme has handled the introduction of two new vaccines. Such introductions are part of a series of Zambian health reforms in which child health interventions form a critical component of the new "basic health care package". However, as Zambia's HSS proposal acknowledges, the existence of a strong health system is a necessary condition for the future successful implementation of immunisation services.

Several reviews have concluded that the main bottleneck in the scale-up of immunisation services in Zambia is what has been termed the "worsening human resource crisis in health". Nurses in particular have been leaving low-paid public sector jobs for positions in the private sector (in both Zambia and abroad), where salaries and working conditions are better. The situation is compounded by staff attrition due to HIV and AIDS. High health worker attrition rates have led to a situation where 50% of rural health centres are run by unqualified staff and community health workers. Even if facilities have managed to retain qualified staff, they are often

chronically under staffed and many do not have the full complement of staff that the nature of the establishment demands. The low staffing levels in health facilities has compromised the quality of health service delivery and led to low utilisation of these services by communities. The inadequacy of appropriate transport is another barrier to improved service provision, and one that is common to many countries where the majority of the rural population has to travel long distances in order to reach health facilities.

GAVI HSS support will be used in 12 districts, and will focus on interventions that (i) motivate health workers (by ensuring good working conditions, including transport as well as a stable water and electricity supply) and (ii) bring services to communities. Zambia's innovative approach to motivating health care staff, and district management teams in particular, involves a number of incentivisation schemes, including one in which the best performers from among the 12 targeted districts will be presented with prizes in recognition of their achievements. In a widely publicised annual awards ceremony – to be graced by a dignitary from the central level – a floating trophy will be presented to the overall winner. Another trophy will be given for “the most improved districts”, rewarding those districts that have improved immunisation coverage by 10%. Other aspects of health service provision

will also be recognised: in this case, awards will take the form shields which will be given to the best health centre and neighbourhood health committee in each of the 12 selected districts. It is hoped that rewarding districts for their hard work and celebrating their success will motivate district management teams.

Zambia's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Proposal\\_3.doc](http://www.gavialliance.org/resources/Proposal_3.doc)

# Results-oriented

*Countries need to be results-oriented in their proposals to GAVI, and clearly demonstrate how the activities implemented with HSS support will address the identified bottlenecks to improved health outcomes. The HSS guidelines state that the impact of the proposed activities should be evidenced at the peripheral level, i.e. at the district and at the service delivery levels. However, the IRC has commented that many proposals are falling short of this requirement, and fail to make adequate links between identified health system bottlenecks and proposed activities to address these bottlenecks.*

*A noticeable weakness of the first sets of applications (i.e. those submitted during the first two rounds of GAVI HSS support) was a lack of baseline indicators. Confusion between output and outcome indicators, and poor prioritisation of indicators were additional shortcomings noted by the IRC who argues that without clear indicators, it is difficult to monitor progress. Although new-style HSS application forms were introduced in early 2007 in an attempt to circumnavigate these types of problems, reviews of the more recent rounds of applications suggest that monitoring and use of progress indicators still needs to be strengthened. The lack of overall plans for monitoring, and the absence of designated units for*

*monitoring and evaluation, were also matters of some concern for the IRC. It appears that many countries are still struggling to identify suitable indicators which fall between process and output, and which would link clearly to GAVI support.*

*It has been a challenge to balance the need for strong GAVI-specific monitoring (which inevitably increases the reporting burden on countries), with the goals of ensuring maximum flexibility of funding, country control of decision-making, and minimal reporting burdens on countries. The issue of monitoring and evaluation is thus one that GAVI will continue to refine as the process continues. The matter was debated by the GAVI Board at its June 2008 meeting, and is expected to be on the agenda for decision at the next board meeting in October 2008.*

## COUNTRY EXAMPLES

*The Democratic People's Republic of Korea*

### **A strong monitoring process**

In its HSS proposal, the Democratic People's Republic of Korea recounts how a combination of economic downturn, natural disasters and limited international support has resulted in a decline in the quality and capacity of its health system infrastructure over recent years. In terms of the management systems, human resource capacity, and financing and infrastructure for operations, these factors continue to act as considerable barriers to immunisation performance. The Democratic People's Republic of Korea thus proposes to link GAVI HSS funds with broader joint



Ministry of Public Health/WHO initiatives in order to rehabilitate and strengthen health systems, and thereby improve and sustain immunisation coverage.

The HSS proposal outlines how the Democratic People's Republic of Korea is developing an overall health system strengthening programme, with four expected outputs:

- 1 quality improvements,
- 2 infrastructure,
- 3 health management systems,
- 4 communication.

The country has requested GAVI funding for output 3, health management systems, and in support of its application has clearly set out how its activities in this area will be coordinated, monitored and evaluated.

The project will be coordinated at central level by the Sector Coordination Committee for Maternal, Child and Neonatal Health. Operational aspects of the project will be overseen by the management committee of the Women's and Children's Project, a joint initiative of the Ministry of Public Health, WHO and Republic of Korea (ROK). The interagency coordination committee (ICC) will provide technical oversight of the HSS-sponsored programme, particularly in relation to measuring the impact on immunisation. At the provincial and county level, the project will be managed and monitored by health bureaus of the Ministry of Public Health. A key outcome indicator will be DPT3-HepB-measles immunisation coverage. Health

system indicators (relating to planning, finance, surveillance and utilisation) have also been identified, and attempts will be made to develop a common monitoring framework.

The Democratic People's Republic of Korea's HSS proposal is available at:  
[http://www.gavialliance.org/resources/DPRK\\_HSS\\_GAVIapplication\\_feb2007.pdf](http://www.gavialliance.org/resources/DPRK_HSS_GAVIapplication_feb2007.pdf)

#### *Sri Lanka*

#### **Measurable objectives linked to well defined outcomes**

Sri Lanka's health indicators are impressive for a low-income country. The HSS proposal describes how successive governments have faced the challenge of maintaining these health indicators in a context of conflict, increased poverty (especially among plantation workers), and competing demands for resources from curative, secondary and tertiary health-care provision. Drawing on existing analyses, the HSS proposal delineates three broad priority areas for action – to be supported through a mix of internal and external funds including GAVI HSS support. These are:

- 1 human resources development,
- 2 sustaining health-care infrastructure,
- 3 strong supervision to support and promote good quality service delivery.

With these overarching goals in mind, the Sri Lankan proposal proceeds to identify three clear objectives for support, as follows:

- 1 to increase primary health care staffing levels (in the correct skill mix) in 10 under-served districts to that of the national norm by 2012 (i.e. 1 public health midwife per 1,500 population);
- 2 to ensure availability of basic infrastructure and logistics to meet national standards in 10 under-served districts for delivery of maternal and child health services by 2012;
- 3 to ensure adequate monitoring and supervision of maternal and child health services carried out in 10 under-served districts by middle-level facility managers by 2012.

Sri Lanka's HSS application provides a model example of a results-orientated proposal: programme objectives, activities and expected outcomes are well defined and clearly presented in a tabular format and the accompanying text and supporting documentation clearly demonstrates the linkages between them. The IRC also commended Sri Lanka's proposal for having a well developed monitoring and evaluation component. Impact and outcome indicators, with baselines and targets, are clearly set out and well explained. Likewise, the sets of process and output indicators are coherently presented. Sri Lanka's HSS proposal has also been singled out because of the level of detail it provides. The inclusion of an annex listing the selected under-served districts and their characteristics was commended by the IRC as it demonstrated that the areas of operation had been determined in advance. This level of detail and foresight is lacking in many other proposals.

Sri Lanka's full HSS proposal is available at:  
[http://www.gavialliance.org/resources/13\\_Sri\\_Lanka\\_HSS\\_application.doc](http://www.gavialliance.org/resources/13_Sri_Lanka_HSS_application.doc)

Sri Lanka already has very high immunisation coverage and a well-functioning health system, but pockets of lower coverage remain. The country plans to use GAVI HSS funds to strengthen infrastructure and logistics to reach ten under-served districts. Community midwife Saroji uses a scooter to reach the households in Hittatiya community, Matare district, south-western Sri Lanka."



### *Tajikistan*

#### **Clear links between identified problems, proposal objectives and activities**

A mountainous central Asian country, Tajikistan is one of the poorest countries in the world, with a per capita GNI of US\$ 380 and more than 80 % of the 7-million strong population living below the poverty line. The HSS proposal explains, "Many people cannot afford the costs of transportation, drugs, and other expenditures for health services. This leads to self-medication and home deliveries that in turn affect the immunisation coverage." The main goal of Tajikistan's HSS support is "to improve access to and demand for basic health services in poor, hard-to-reach areas through increased financial commitment of the government at all levels, creation of outreach services, and improvements in the quality of physical and human resources". Five key bottlenecks have been identified, each of which is linked to a specific programme objective. These are:

- (i) to strengthen evidence-based decision-making at central and local government levels in order to build financial commitment for primary health care and public health services;
- (ii) to increase access to primary health care services in remote hard-to-reach areas;

- (iii) to strengthen the capacity of primary health care and public sector staff, according to the updated and harmonised guidelines that integrate integrated management of childhood illness (IMCI), vaccine-preventable diseases (VPD) and adverse events following immunisation (AEFI) surveillance;
- (iv) to increase demand for timely immunisation through increased awareness and development of a system of incentives for mothers;
- (v) to increase the capacity of primary health care facilities to collect and report data in a timely manner, to base decisions on these data and to use them for planning.

In its review of the proposal, the IRC commented that each objective is presented with clearly delineated activities, expected results and timelines for implementation. Tajikistan's HSS proposal is available at:  
[http://www.gavialliance.org/resources/Tajikistan\\_HSS\\_2008.pdf](http://www.gavialliance.org/resources/Tajikistan_HSS_2008.pdf)

# Sustainability-conscious

*The ultimate goal of GAVI HSS funding is to enable long-lasting system changes that will facilitate robust systems well beyond the time frame of GAVI funding. In order for that ambition to become a reality, there has to be a clear commitment to continue the support for these system changes from within the country. For this reason, the HSS guide-lines stipulate that “countries should consider the financial and technical sustainability of GAVI HSS support and describe how they expect to sustain the recurrent costs and impact of GAVI HSS support beyond the life of GAVI funding where relevant”.*

*This cross-cutting requirement has been a challenge for many countries to fulfil in their proposals, given that countries are expected to address sustainability through the development of financial sustainability plans (now replaced by comprehensive multi-year plans for immunisation), to co-finance new vaccines, and also to focus on programme efficiency in all forms of GAVI support.*

## COUNTRY EXAMPLE

*The Gambia*

### **Fund-raising to strengthen sustainability**

Reviews undertaken to inform the new national health policy framework revealed that while there has been progress in health outcomes in recent years, reaching the Gambian population of about 1.5 million remains problematic. Although the average per capita GNI is US\$ 290, around 70 % of the rural and 40 % of the urban population are classified as living in poverty. With its GAVI support, as well as funds from other sources, The Gambia plans not only to boost immunisation coverage but also to strengthen health infrastructure and data collection and management.

Uniquely, The Gambia has included “mobilise additional resources to sustain the gains after GAVI HSS by 2015” as one of six objectives in its HSS proposal. To achieve this objective, activities such as ensuring high-level political buy-in by involving the president and partners in launching GAVI HSS implementation, organising regional fund-raising activities, and mobilisation of resources from local donors have been proposed.

# Stronger financial management and monitoring

*Effective health systems need robust financial management systems to ensure that fiduciary risk is minimised, and that accountability and planning processes are both strong and transparent. Although financing and budgeting is not a guiding principle for HSS support per se, it is nevertheless an issue that the IRC has raised and consideration of the financial arrangements forms an important component of the IRC's assessment of proposals. A recent review of HSS applications also highlighted the fact that financial aspects of many proposals, including the budgets, are poor.<sup>7</sup> The IRC has, for instance, received proposals where financial data were missing, or where there were inconsistencies within the same document. In some cases, it has been difficult to determine whether or not the unit costs quoted in proposals are realistic. In order to improve the quality and accuracy of cost estimates, the IRC has advocated for a greater involvement of development partners at country levels. To date, in some cases, partners' increased support has resulted in more realistic unit costing in countries' HSS proposals.*

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<sup>7</sup> *Country initiatives to lift health system constraints. Lessons from 49 GAVI-HSS proposals.* Geneva, WHO/UNICEF/GAVI Alliance, 2008 (WHO/HDS/HGS/2008.1)

## COUNTRY EXAMPLE

### *Nigeria*

#### **Detailed breakdown of costs**

With a population of 140 million, Nigeria is Africa's most populous country. In spite of modest improvements in maternal, child and infant mortality, and also in immunisation coverage, the health system still faces major barriers to improved provision. These include inadequate funding, shortage and maldistribution of human resources for health, general infrastructural decay, the lack of a harmonised and efficient logistics system, a weak national health management information system, as well as inefficient health programme

management. The goal of the HSS proposal is therefore to strengthen the national health system and reposition it to deliver effective, efficient and sustainable health services, within the country's health sector reform programme.

As part of its HSS proposal, Nigeria has provided a detailed breakdown of all costs, including unit costs, conveniently presented in a spreadsheet format. The IRC commented that it found the table to be a useful source of verification for queries pertaining to the budget, without which it would have been more difficult to find answers to queries. The IRC therefore recommends that this particular table be emulated by other countries submitting applications for GAVI HSS support.

The relevant table is included in Nigeria's HSS proposal, which is available at:  
[http://www.gavialliance.org/resources/6\\_Nigeria\\_HSS\\_application.doc](http://www.gavialliance.org/resources/6_Nigeria_HSS_application.doc)



**The goal of Nigeria's HSS proposal is to strengthen the country's national health system. In Bauchi State in northern Nigeria, House Assembly member Hajia Habiba Sabo Gabarin (in red) visits a clinic that provides immunisation services..**



