



The GAVI Alliance
Civil society organisation
Type B funding

Case studies

Afghanistan

DR Congo

Ethiopia

Pakistan

The GAVI Alliance Civil society organisation Type B funding

Case studies

CONTENT

Introduction	4
1. Afghanistan	6
2. DR Congo	22
3. Ethiopia	39
4. Pakistan	55



Acknowledgements

This study would not have been possible without the important information and perspectives provided by those involved in the GAVI Alliance civil society organisation (CSO) grant in Afghanistan, the Democratic Republic of the Congo, Ethiopia, the and Pakistan, particularly those from the health ministries, the CSO community and the GAVI Alliance partners in those countries. Special appreciation goes to Molly Fitzgerald, Betsy Williams, Marie Tien and Lora Shimp (all JSI) who carried out desk reviews, conducted interviews and provided extensive review. And lastly, we would like to thank Robert Steinglass of JSI and Nilgun Aydogan of the GAVI Secretariat who provided guidance throughout this process and who really are champions of the international CSO community and the importance of partnerships in country.

The experts interviewed have requested that specific quotes are not attributed to individuals.

Wendy B. Abramson, John Snow Inc.



Introduction

a) Study background and civil society organisation definition

In November 2006, the GAVI Alliance (GAVI), under its health system strengthening (HSS) window, launched a new type of funding to support civil society organisations (CSOs). GAVI recognises the importance of utilising all resources available in-country to strengthen the health system through fortifying access to care, particularly to immunisations. The GAVI support to CSOs includes two components. Component A, with provision for all GAVI-eligible countries, is designed to map out and strengthen country-specific coordination and representation of CSOs. Component B, with provision for CSO activities in 10 pilot countries, provides direct funding to CSOs and is designed to complement HSS proposals and align with comprehensive Multi-Year Plans (cMYPs). The GAVI support to CSOs is intended to encourage an increase in involvement of CSOs in immunisation, child health and HSS, and to develop closer working relationships between the public sector and civil society in the delivery of health care, particularly immunisation.

The purpose of these case studies is to document experiences and lessons learned under the GAVI CSO grant, including the application and selection process, implementation to date, and monitoring and reporting.

For purposes of the GAVI Alliance support to CSOs, the following definition of CSOs will be used: community-based organisations in countries, consortiums of non-governmental organisations (NGOs) in health, professional associations, specialised technical assistance organisations, international and local health consulting groups, and NGOs responding to emergencies in countries in crisis.

Non-for-profit healthcare providers offer services either for free or for a nominal fee, cater to all socioeconomic levels, offer the same vaccines as those found in the national programme, and often provide services in places where access to government health services is low. This sector includes international NGOs, local NGOs, and mission facilities. The relationship between the government and non-for-profit sector ranges from the public sector conducting little to no oversight to various levels of regulation and monitoring of the NGOs. In some countries, governments and/or donor agencies contract out or with the NGOs to provide services. It should be noted that some NGOs do not provide immunisation services but play an important advocacy role for immunisation, particularly for campaigns and national immunisation days (from Levin, Miloud 2009).



b) Purpose and objectives

By strengthening the coordination and representation of CSOs in national-level coordination mechanisms, the GAVI Alliance support is designed to facilitate the following:

- greater understanding of CSOs working in immunisation, child health and health system strengthening;
- more representative and vocal civil society inputs to national planning and implementation;
- stronger capacity at the country level to support communities, increase immunisation coverage, and deliver immunisation, child health care and health system strengthening activities; and
- increased cooperation and coordination of efforts between the government and civil society.

The purpose of this paper is to document best practices and lessons learned from CSO and government collaboration in the Democratic Republic of the Congo, Ethiopia, the Islamic Republic of Afghanistan and Pakistan. In particular, this paper will highlight processes and practices supported with GAVI CSO Type B funding related to hard-to-reach populations, technical assistance and capacity-building and social mobilisation and advocacy. The information was collected in November 2009.



Case study 1: Afghanistan

Overview of GAVI funding windows and support

Afghanistan was approved for GAVI **immunisation services support** funds in 2001 and as of May 2008 had received a total of US\$ 15,286,000 in approved funding.¹ GAVI **injection safety support** for Afghanistan ended in 2006. Current injection safety supplies are provided by the United Nations Children's Fund (UNICEF), and injection safety training to Adverse Events Following Immunization (AEFI) is included in all refresher training courses for vaccinators.² UNICEF continues providing autodisable syringes, injection supplies and safety boxes, while supplies for non-vaccine injectables are provided by the Ministry of Public Health (MoPH) as part of the Basic Package of Health Services (BPHS).

Through the **new vaccines support**, in 2006 Afghanistan began the phased introduction of the tetravalent vaccine (DTP3 + HepB) (US\$ 6,000,000) and made plans to introduce pentavalent vaccine (DTP3 + HepB + Hib) in 2009. Over US\$ 45,000,000 has been approved for these activities. Belgium and India each supplied nearly 2,500,000 doses of DTP3 + HepB vaccine in 2007; no problems were reported in the receipt or distribution of the vaccine.³ Unfortunately, immunisation coverage continued to be hampered by insecure geographic barriers and unclear responsibilities.

The **GAVI HSS** grant was funded from 2007 through 2011 for a total approved amount of US\$ 34,100,000, of which US\$ 6,700,000 was received in 2007; a revised plan for US\$ 10,091,209 was made for 2008; and an additional request of US\$ 7,017,904 was made.⁴⁵ The HSS grant seeks to increase access to quality health care, increase demand for mother and child health services, and improve the ability of the MoPH at various levels to fulfill its oversight responsibilities. The objectives of the HSS grant are to (a) improve access to quality health care, particularly maternal and child health, (b) increase demand for and utilisation of mother and child health care services, and (c) improve the ability of the MoPH at the provincial level to fulfill stewardship responsibilities.

¹ GAVI Alliance Fact Sheet

² GAVI Annual Progress Report 2007

³ MoPH Gavi Annual Progress Report

⁴ GAVI country overview

⁵ MoPH Gavi Annual Progress Report



I. Methods – Key informants and study limitations

Data collection for this case study began with a literature review of all documentation relevant to the GAVI Alliance CSO grant in Afghanistan, other GAVI Alliance support, HSS work in the country, all GAVI Alliance and task team trip reports and notations, and literature on fragile states in general and the Islamic Republic of Afghanistan in particular.

A semi-structured interview was carried out with selected informants with knowledge of and direct experience with the GAVI support Type B process in Afghanistan. Attempts were made to contact representative groups, including: coordinating body members of the CSO consortium or umbrella group; CSO groups involved in the consultative and application processes; Health Sector Coordinating Committee (HSCC) and/or Interagency Coordinating Committee (ICC) members; MoPH staff from the Expanded Programme on Immunization (EPI) and/or Division of Child Health or/and Division of Planning; and GAVI Alliance partners in country, such as the World Health Organization (WHO) and UNICEF. Outreach was made by telephone and email. Of the 10 individuals contacted, four responded positively, at which time a list of interview questions was shared with them and phone interviews were carried out.


The main limitation of this study is that due to the short time frame involved for data collection, and, in the case of Afghanistan, safety concerns about the election, it was not possible to conduct interviews in person. Unfortunately, the research was conducted during a period of great political uncertainty as the run-off election process was in flux, which further complicated attempts to reach participants.

II. Country context

The Islamic Republic of Afghanistan, located in Southern Asia, has a population of 28.4 million; 44.5% are 0 to 14 years of age, 53% are 15 to 64 years of age, and 2.4% are 65 years of age or over⁶. Decades of war, drought and displacement have resulted in some of the worst health indicators in the world: in 2006, the Infant Mortality Rate (IMR) was 129/1,000 live births, the under-5 Mortality Rate (u5MR) was 191/1,000 live births, and the Maternal Mortality Ratio (MMR) was estimated at 1,600 for every 100,000 live births. While poor, these rates indicate progress in the health sector since 2001, representing a 25% reduction of IMR and MMR.⁷ Life expectancy at birth is 47 years for Afghan men

⁶ CIA World Factbook

⁷ Ministry of Afghanistan HSSN Strategy 2007 – 2013



and 45 years for Afghan women. Until 2001, CSOs and NGOs as well as private providers were the main service delivery providers in Afghanistan, with little to no regulation or oversight by the State.

Since the fall of the Taliban in 2001, there has been considerable progress made in consolidating the health sector in Afghanistan. The 2005-2009 National Health Policy and National Health Strategy articulates a 10-year plan whereby the MoPH is “committed to ensure the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to under-served areas of the country, and through working effectively with communities and other development partners.”⁸

The majority of health service delivery in present-day Afghanistan is provided by CSOs under contract by the MoPH which has contracted out the BPHS Essential Package of Health Services (EPHS) for 31 of 34 provinces to NGOs. It has also consolidated its leadership role and is focusing on policy development and oversight of the health system in Afghanistan.⁹ Contracts for the BPHS are being funded by three development agencies: the United States Agency for International Development (USAID), the World Bank and the European Commission.¹⁰ The MoPH directly provides BPHS to the Afghan population in three additional provinces.

United Nations (UN) agencies supporting the health sector include UNICEF, WHO, the United Nations Population Fund (UNFPA), and the Joint United Nations Programme on AIDS (UNAIDS), with additional support from GAVI and the Global Fund to Fight AIDS, TB, and Malaria (GFATM). Other bilaterals supporting the health sector in Afghanistan include Canada, Estonia, France, Germany, India, Iran, Italy, Japan, New Zealand, Norway, Pakistan, Saudi Arabia, Spain, South Korea, Turkey, Turkmenistan, United Arab Emirates and the United States.

Health services are provided as an integrated package in BPHS and EPHS facilities. Basic Health Centres (BHCs), Comprehensive Health Centres (CHCs) and District Hospitals (DHs) provide basic essential obstetric care services, and comprehensive obstetric care is provided at district and provincial hospitals. Immunisation is included as one of the key components of the BPHS; and planning, staffing, training, educating and supervising immunisation activities at the local level are the responsibility of the contract NGOs implementing the BPHS.

⁸ Ministry of Public Health, Afghanistan, a Health Policy and Strategy 2005-2009

⁹ Sidiqi

¹⁰ Annual Report



Overall Expanded Programme on Immunization

Immunisation was included as one of four targets in the government's "Afghanistan Compact 2006," a document reflecting the country's commitment to meeting the Millennium Development Goals. Under the Afghanistan Compact of 2006, the Basic Package of Health Services was laid out as the cornerstone of the country's health strategy, as well as the plan for implementation of that package of services through contracts with NGOs.^{11 12} The goals set forth in the National Health Plan and Strategy of 2005-2009 have been integrated into the Health and Nutrition Strategy (HNSS) for the years 2009-2013; Importantly, "full immunisation coverage" is included as one of four specified results to be achieved by 2013, indicating the central importance the government in general and the MoPH in particular has placed on immunisation activities.

Funds received from GAVI are included in the MoPH's core budget and used for EPI activities as outlined in the Country Multi-year Plan (cMYP) and in consultation with the ICC. It was the cMYP of 2001-2005 that served as the national operational plan for immunisation system development and also allowed Afghanistan to meet the conditions for accessing GAVI grants for immunisation system strengthening and injection safety. As outlined in the cMYP, immunisation activities are funded by GAVI support (20%), UNICEF (35%), and other donors such as the World Bank, WHO, the European Commission and USAID (17%). The government directly funds the majority of staff salaries and almost all building and infrastructure-related expenses (20%). With immunisation embedded in the package of primary health services, all MoPH departments are responsible for facilitating improved immunisation coverage, and the National EPI is further involved in overall stewardship of the planning, policy making, advocacy, coordination and monitoring of EPI services. Total expenditure and financing for EPI was nearly US\$ 80 million for the two-year period 2006 through 2007.

Although the economic situation in Afghanistan remains fragile, the government contributed at least 8% of the routine immunisation costs in 2006 and 2007; this is reflective of its high political commitment to these activities. While Afghanistan will likely require the support of external funding for the near future, strategies are under development to improve financial sustainability, including improving the mobilisation of resources from government, donors and private sector for immunisation; increasing the reliability of resources through budgeting and reporting; and increasing the efficiency of resources by promoting integration and reducing vaccine wastage. In addition, it is expected that as Afghanistan builds its own capacity to generate resources, it will increase its own contribution towards immunisation financing and thus the financial sustainability of the EPI.

¹¹ GAVI HSS application

¹² Afghan Annual Report

Civil society organisations - historical perspective

Civil society organisations have a vibrant and diverse history in Afghanistan, dating back hundreds of years when local community tribal *shura* were responsible for dispute resolution.¹³ CSOs in the form of modern NGOs were established towards the end of the 1980s and early 1990s during the Mujahedeen and Taliban periods, at which time there was a focus on humanitarian relief efforts immediately after the Soviet invasion.^{14,15} During this period, international NGOs worked through local NGOs without any oversight from the government.¹⁶ Most of them were based in Islamabad as much of this

“CSO support could be very effective because CSOs are flexible and can be less targeted by opposition.”
Health System Strengthening Coordinator and Focal Point, MoPH

work was on the Afghan-Pakistan border. Although NGOs initially focused on providing humanitarian relief, in the early 1990s they started to undertake projects related to development.¹⁷ However, it is in the period following the fall of the Taliban in 2001 that CSOs in Afghanistan began to really flourish. From 2001 to 2002, during an initial period of transitional government and state building, the only way to reach the population was through the CSOs’ outreach.¹⁸ In the health sector, NGOs and CSOs have a long history of involvement and have proven to be particularly valuable in reaching marginalised populations and people in remote areas, especially through community mobilisation.

Through the work of local and global CSOs, millions of children have been immunised—protecting them against disease and early death. The role of CSOs in community outreach and advocacy is further endorsed in the 2008 ANDS, which articulates their role as MoPH contractors for service delivery, outreach and advocacy.

Overall, the provision of immunisation services through health facilities and community outreach in Afghanistan has improved, despite security problems, geographical constraints and health worker shortages. Still, more effort is needed to ensure comprehensive and equitable coverage.

¹³ Interview with Dr. Sidiqi

¹⁴ Waisova

¹⁵ Rana

¹⁶ Rana

¹⁷ Waisova

¹⁸ Sidiqi



III. The GAVI CSO grant proposal and application process


There was a concerted effort by the MoPH, the GAVI Secretariat and WHO to engage as many national CSOs as possible in the application and proposal development processes. The Consultative Group on Health and Nutrition (CGHN)(which is the equivalent of the Health Sector Coordination Committee in Afghanistan) and the HSS Coordinator in the General Directorate of Policy and Planning at the MOPH both played a major role in including as many stakeholders from civil society as possible in the introduction of the grant proposal and guidelines. In early 2008, the MoPH and the WHO representative in country developed a list of over 800 organisations working in the country, including both international and Afghan university groups, traditional trade associations, service delivery organisations and many groups from outside the health sector. All 800 were sent an invitation to participate in an orientation workshop about the GAVI Type B application guidelines and to discuss how best to increase immunisation coverage rates in Afghanistan. Over 120 entities responded with interest; unfortunately, due to logistical constraints, the organising team agreed on final invitations to only 40 CSOs. These were selected with the following criteria: ongoing relevant health programmes and activities in country; presence in marginalised and remote areas; and representation of a mix of organisation types (academic, international, regional, professional association, etc.). A total of 24 CSOs participated in the first workshop held in January 2008, and another 40 in the second workshop held later the same month.¹⁹ The CSOs elected an interim representative who provided guidance and coordination throughout the proposal development stage.

To avoid any duplication of efforts in the field, during the workshops, considerable effort was made to support activities that were linked to and aligned with already ongoing activities. The specific objectives were to:

- Present the mission, vision and objectives of the GAVI Alliance;
- Update the CSO community on progress made in Afghanistan to date through other GAVI funding mechanisms;
- Familiarise CSOs with the objectives and guidelines of the GAVI CSO Type B funding; and
- Reach consensus on implementation mechanisms for use of the GAVI CSO funds.

The last point was very important and targeted not just CSOs but also government partners, the HSS Steering Committee and current GAVI-supported partners.

¹⁹ Aydogan, Afghan Trip Report



Much of the workshop was dedicated to group work in which participants, using the Democratic Republic of Congo's CSO proposal as an example, identified areas where they felt they would be able to contribute towards strengthening the health system. From these discussions a list of key thematic areas emerged and consensus was reached that final decisions regarding CSO eligibility, budgetary conditions and strategic implementation would be best defined and announced by the GAVI Alliance HSS Steering Committee, which provides guidance and oversight for all GAVI HSS grants and activities.

From these workshops and subsequent conversations and meetings between CGHN, the HSS Steering Committee and WHO-EMRO, two principal activities emerged as key strategies under the GAVI CSO grant: (1) Community Midwifery Education (CME) training and (2) establishment of a replicable model of partnership with private service providers to increase access to immunisation and basic reproductive health services. For implementation of these activities, the provinces identified the need to target the most difficult-to-reach populations in high conflict areas where clearly there is a huge service delivery gap.²⁰ Grant activities not only complement efforts by the MoPH and NGOs to increase access to the BPHS, but they also strengthen collaborative partnerships with CSOs. The MoPH sought to increase the participation of local NGOs by encouraging partnerships with other more experienced NGOs.


The GAVI CSO grant proposal process was competitively bid, and several CSOs submitted proposals to work in the same geographic areas. A panel composed of representatives from UNICEF, the Ministry of Finance, WHO, MoPH, and the Midwives Associates ranked and evaluated the proposals and selected the strongest applicants for approval.

IV. The GAVI CSO grant implementation process

Four CSOs/consortiums were selected to implement the CME in the underserved provinces in Ghanzi, Faryab, Nimroz, and Zabul:

- IbnSina
- Save the Children (SC/US) and Agency for Assistance and Development in Afghanistan (AADA) consortium
- Balhtar Development Network
- BRAC Afghanistan.

²⁰ GAVI Type B proposal



One CSO and one CSO consortium were selected to establish a replicable model of partnership with private health services providers to provide Immunisation and basic reproductive health services in two conflict areas—Farah and Uruzgan:

- Coordination of Humanitarian Assistance (CHA)
- HealthNet TPO and Humanitarian Assistance and Development Association for Afghanistan (HADAAF)

Focus on the female health worker

Although female health workers are critical to the use of health services by women, in the four provinces selected under the GAVI CSO grant only 56% of the health facilities have at least one female health worker. This lack of presence of female health workers is one of the principal obstacles to utilisation of reproductive health and immunisation services by women. To respond to this service gap, the CME initiative will seek to recruit, train and deploy 88 new community midwives, thereby enhancing the pool of trained health workers available to fill this service delivery gap.

This first component uses a successful and well-received 10-month CME course developed and endorsed by the MoPH. In addition, the four CSOs selected under the GAVI proposal will abide by the recruitment and employment policy adopted by other partners in Afghanistan, whereby recruitment is done in accordance with geographic need and a commitment by the students to work in facilities located in the geographic areas of origin. A provincial-level coordination committee—composed of provincial health staff, NGOs implementing the BPHS, and community members—will steer the selection of trainees in partnership with the selected CSO. This selection will be done in accordance with MoPH guidelines and minimum selection criteria for community midwives: female, 18 years of age or older, demonstrated community support (letter from shura or similar), minimum nine years of education and passing grades on entrance exam.

This approach to recruitment and retention has already had demonstrable results. In 2002, there were only seven such training programmes in the entire country, resulting in just 462 trained midwives. By 2008, with the introduction of the revised CME curriculum and increased support from donors, there were over 2,000 midwives trained, resulting in a subsequent rise in the number of births attended by a midwife from 6% in 2002 to nearly 20% in 2008.²¹ The flexibility of the GAVI CSO grant created the opportunity for new CSO partners to become involved in this effort, allowing the programme to come to scale by increasing the number of students trained and the its overall geographic outreach.

²¹ UNICEF



Specific activities include:

- Recruitment of women for training (in close consultation with community elders and health facility workers);
- Establishment of standard training site;
- Implementation of skills training for student community midwives;
- Self-assessment of CME programme;
- Independent assessment of graduates by the National Midwifery Education and Accreditation Board; and
- Deployment of CMEs to BPHS facilities.

Increase in private sector outreach

Due to security issues as well as geographic remoteness, there are huge areas of Afghanistan that have very low access to health services. This is especially true in Uruzgan and Farah provinces located in the south, where more than 40 government (contracted) health facilities were closed last year due to armed conflict. In Uruzgan, three NGO staff were killed and three others kidnapped. Farah has experienced mass outbreaks of polio, measles and pertussis over the last three years due to an utter lack of immunisation outreach and access to services.

A 2006 study by the Afghanistan Research and Evaluation Unit found that private sector health partners, especially pharmacists and medical dispensers, play a significant role in health care delivery in conflict zones, suggesting that there could be a benefit in using these networks for the provision of immunisation and reproductive health services. The second component of the CSO grant seeks to start that process.

“It is the CSOs who are the only ones operating at the field and in the rural areas. While in the beginning each CSO had its own coping mechanism and way of solving problems, under the leadership of the MoPH all stakeholders are working together. There are formal and informal ways for the NGOS to identify and share problems and concerns from the field back up to the central level. This is sometimes the only way that MoPH and donors know what is really going on.”

Health System Strengthening Coordinator & Focal Point, MoPH



Specific activities include:²²

- A mapping exercise to determine the number and types of private service providers and pharmacy outlets in the Farah and Uruzgan provinces;
- Training of selected private service providers, especially in immunisation and preventive health skills;
- Provision of necessary equipment;
- Activities to create demand;
- Enhancement of coordination and cooperation between public sector and private sector health service providers; and
- Project monitoring, evaluation of outcomes, documentation of and sharing achievements and lessons learned with stakeholders.

Specifically, the private sector project will seek to establish a private practitioners association in each of the two provinces. It is expected that the associations will oversee and regulate performance of private providers and subsequently increase the consistency and quality of health service provision and outcomes. Another intended outcome from this activity is strengthening provincial governance in the health sector.

Financial disbursements

There were delays in signing the final grant agreement and disbursing funds due to confusion over the best mechanism for fund management. Although it is not customary for multilateral organisations to take on responsibility for financial management of these types of projects, WHO has agreed to manage the GAVI CSO funds through a Memorandum of Understanding between MoPH, WHO, and the GAVI Secretariat. After lengthy internal discussions on WHO fund management, an allotment number was just assigned to the grant, and funds are now available for disbursement (October 2009).


Although the delay in disbursement and the unplanned role of WHO as project manager were both unforeseen events, those interviewed felt that these delays were not entirely negative in that they allowed the CSOs and NGOs to carry out pre-implementation activities that they may not have otherwise had time to conduct.

Coordination, monitoring and evaluation

Even prior to the deployment of the GAVI CSO grant, there was strong communication and coordination between the health ministry and the CSO community.²³

²² GAVI Type B proposal

²³ Interview with Dr Wali



Today, MoPH and CSOs communicate at several different levels. At the district level, district health committees are the fora where CSOs discuss service delivery, advocacy strategies and protocols with district-level stakeholders, including the district health officer representing MoPH. Similar discussions take place at the provincial level, with provincial coordination committees as the focal point for meeting. At the national level, CGHN, the Afghan version of the Health Sector Coordination Committee, is the vehicle through which CSOs can discuss issues and share information with higher Government decision makers.

“There was little actual change in communication between CSOs and Ministry stakeholders because the CSOs already had very strong representation but this strengthens it.”

Health System Strengthening Coordinator & Focal Point, MoPH

In order to ensure fluid coordination between the MoPH and the CSO

community under the GAVI CSO grant, monthly meetings have been established. These meetings are led by the Executive Board of the MoPH (CGHN) and the Directorate of Policy and Planning, the unit within the MoPH responsible for HSS Coordination.


V. Findings and recommendations

The GAVI CSO support Type B enables the CSO community to contribute to the health sector in general and to improvements in health outcomes through the following mechanisms:

- Increasing access to reproductive health and immunisation services to women and in difficult-to-reach, unstable geographic locations;
- Facilitating expansion of a female health worker-focused training module for midwives;
- Introducing a pilot partnership between the private sector, the community and the MoPH in hard-to-reach, high-conflict and fragile areas;
- Introducing a competitive relationship in the health sector between bidders; and
- Expanding the network of CSOs eligible to compete for funding.

Participatory process and state building

Overall, the proposal and application process was quite participatory although there were some very important challenges. Suggestions for future grant design and implementation are highlighted below.



Despite considerable effort to reach out and engage smaller and previously overlooked CSOs, especially national ones, for the most part participants in the application design and the following bidding process were the same NGOs that were already familiar with the health sector. As it was, the government and technical advisor put considerable time and effort into supporting proposal development at all levels. From the ministry's perspective, this rather time-consuming activity and the relatively low level of funding did not make this activity as valuable to the government as other activities have been.

The time spent in convening and recruiting CSOs may have been lengthy, but

“Because of all of the contracting out for services, the capacity-building functions have not been very active, especially for Afghan organizations. There are more international NGOs getting the contracts since they have developed systems; they are at an advantage compared to the local organisations. This creates a major gap. And it [this gap] is not necessarily being addressed by donors.”


CSO Partner

in order to ensure political and social buy-in to the project goals and objectives, this huge commitment up front was necessary. Unfortunately, the necessary resources to strengthen the capacity of local CSOs to participate in discussions and be part of the proposal and application processes were not made available early on. That said, many of the CSOs that applied were weak in both operational and implementation capacity as well as in accounting and finance. The government recognised the value of including these organisations, but lamented that the resources were not adequate to provide the necessary support for including them.

The health ministry wanted to ensure that the GAVI CSO application process was competitively bid out although it was difficult to achieve broad participation due to time constraints. In its evaluation, the panel discovered that a great deal of technical and financial review was needed to ensure that the methodology employed by the CSOs was of high quality; however, the time allotted for this evaluation process was insufficient to do so.

Despite the enormous amount of effort to expand the number of CSOs included in the GAVI CSO grant pre-application process, only those with a proven track record of collaboration with the MoPH and GAVI were selected to receive GAVI CSO funding.

In the future, it may make sense to reconsider the strict criteria guidelines in order to avoid the cycle of the same CSOs with experience winning new projects, which detracts from opportunities for new partners to collaborate, learn and effectively build relationships and trust between civil society and the State. GAVI may consider that the selection criteria be revisited in order to allow greater inclusion



of CSOs as implementers. The GAVI application process did encourage partnerships between local CSOs and large international NGOs through consortiums. The encouragement of this partnership was innovative and a way to overcome some of the human resource and capacity issues in Afghanistan, and even greater emphasis on such partnerships should be encouraged in the future. In addition, it may be feasible to build in a longer-term capacity-building component for international CSOs to work with local Afghan organisations.

Fund management

Although the delay in fund management in the end enabled the CSOs to properly prepare for implementation, this is an issue that could have been worked out before the introduction of the application and guidelines in order to avoid such a delay.

Political environment

And lastly, because issues of political stability are always in the forefront in fragile states—particularly in the case of Afghanistan where there is no denying that a war is underway and security is increasingly becoming an obstacle to access to health care services—GAVI investments may need to be greater than in non-fragile states to achieve the same results. In an environment where the public health system is 100% externally funded, it is critical that the process encourage creative problem-solving and a longer-term vision, aiming for positive rather than quick results. Involvement of CSOs is critical in Afghanistan as they are often the only ones who are not in danger through the insecurity in the country.

The application and selection processes need to be tailored to fragile states since traditional processes do not usually apply in these countries. There should be caution in terms of expecting “immediate results.” As mentioned previously, a greater investment up front in strengthening the partnerships and capacity of CSOs may be more costly financially but will bring high returns over the long term.

The research for this case study was conducted during a period of great political uncertainty in Afghanistan, as it coincided with calls for a run-off election. This is a reminder that there are a number of critical risks and assumptions in the GAVI project that are beyond the control of the CSOs or MoPH.



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Annex II: List of interviewees

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Dr Abdul Majeed Siddiqi

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Dr Sidiq

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Case study 2: Democratic Republic of the Congo


I. Overview of GAVI funding windows and support

GAVI Alliance support to the Democratic Republic of the Congo (DR Congo) began 2002. The **injection safety support** began in 2003 and ended in 2008. Since then, the Government of the Democratic Republic of the Congo has not taken up the funding of syringes or safety boxes. The United Nations Children's Fund (UNICEF) is currently funding vaccines and supplies, a stop-gap measure that may continue until a permanent alternative, such as increased Government budgeting and financing, is put into place.

Through the **new vaccines support**, new vaccines totaling US\$ 81 million were purchased directly by GAVI from UNICEF/Copenhagen and forwarded to DR Congo. A first shipment of Tetravalent vaccine (which contains four antigens: diphtheria, tetanus, pertussis and hepatitis B (DTP-HepB) was shipped to DR Congo in 2007 and a second in 2008. DR Congo introduced HepB combined with DTP (known as Tetravalent) in 2007 and in 2009, introduced Hib combined with tetravalent which became Pentavalent (DTP-HepB-Hib). Pentavalent vaccine introduction began in 2009. Nevertheless, the government is not meeting its financial share of the cost of these vaccines, as outlined in the gradual transfer of financial responsibility from GAVI to the government. In addition, a line item for vaccines is still being worked out between the Ministry of Health (MoH) and the Ministry of Finance.

Immunisation services support funds are not part of the MoH budget but have been managed by the Expanded Programme on Immunization (EPI)²⁴. These funds are approved based on a yearly work plan submitted by the EPI and approved by the Inter-agency Coordinating Committee (ICC). ISS funds were used to finance most cold chain purchases from 2002, with the remaining funded by donors in their respective geographic zones. With the ISS grant ending in 2009, the EPI programme manager advocated to the MoH to continue cold chain purchases through the regular MoH budget, but this has not occurred. As an alternative, during the 2009 HSS budget preparation, the EPI requested US\$ 5 million but received only US\$ 1.5 million. There are no specific line items for EPI cold chain purchases in the HSS grant, but medical equipment purchases are

²⁴ Due to misuse of funding, an external audit was carried out by a local accounting firm over the period of 2003-5, which identified the following: a lack of a sound accounting system; non-existent budget-monitoring system; non-existent recording system for expenditures and receipts; and deficient inventory (products and office supplies) system.



identified. The cold chain equipment will be distributed to most health zones, with priority given to those where there is a gap between what is needed and what is available from other sources.

The GAVI Alliance **health system strengthening (HSS)** funds, totalling US\$ 62.1 million from 2007-2009, are to be used to implement the strategy of revitalisation and development of 65 health zones through the rehabilitation of health facilities (including drugs for facilities) and the improvement of human resources through educational improvements and salary supplements. In addition, the grant is supporting three provinces and the central level. DR Congo's HSS grant aims to extend the National HSS Strategic Plan and address bottlenecks in the system to enable increased coverage of health services.

II. Methods – Key informants and study limitations


The first phase of data collection for this case study was to conduct a literature review on all documentation relevant to the GAVI Alliance CSO grant, other GAVI Alliance support, health system strengthening work in the country, all GAVI Alliance and task team trip reports and notations, and literature on fragile states, DR Congo in particular.

A semi-structured interview was carried out with key informants with knowledge of and direct experience in the country. A list of interview questions was shared with those to be interviewed, and follow-up phone interviews were conducted. Key informants included but were not limited to the following: coordinating body members—CSO consortium or umbrella group; CSO groups involved in the consultative and application processes; Health Sector Coordinating Committee (HSCC) and/or ICC members; MoH staff from the EPI and/or Division of Child Health or/and Division of Planning; and GAVI Alliance partners in country, such as the World Health Organization (WHO) or UNICEF.

The main limitation of this study is that due to the short timeframe involved for data collection it was not possible to travel to country and meet face-to-face with those involved in the GAVI Alliance CSO grant application or implementation.

III. Country context

The DR Congo, located in Central Africa, has a population of approximately 63 million inhabitants and a land surface area of 2,345,000 km². In 2006 the Gross National Income per capita was US\$ 120. Rates of access and utilisation of preventive medical care are low due to over a decade-long war and the poor



governance in the three preceding decades. The DR Congo has one of the highest maternal and infant mortality rates in the world. Its maternal mortality rate in 2006 was estimated at 1,289 per 100,000 live births, and infant mortality was 115 per 1,000 live births. However, since the peace process began in the early 2000s, the overall child mortality situation in the war zones has started to improve, with under-five mortality reportedly declining from 408 deaths per 1,000 in 2002 to 200 in 2006²⁵. Recently, when WHO compared DPT3 coverage for the first quarter of 2007 with coverage for the first quarter of 2008, it found that DR Congo was among the three countries in the WHO African Region where DPT3 coverage appeared to be on the decline.

The DR Congo health system is decentralised, with primary and first-level referral services integrated in the health zones and each health zone serving a catchment population of approximately 110,000.


The Interagency Coordinating Committee(s) at the central and provincial levels

The ICC model was created in 1995, and an organised and formally structured sub-committee on the EPI was solidified in 1998. At the provincial level there are many partners assisting health zones as part of the EPI, including NGOs, churches, and various projects. These partners provide significant resources to health zones and/or to EPI facilities at this level, including cold chain equipment, transportation materials, computer equipment, subsidies for supervision activities, and in some cases, a bonus for personnel based on performance. Although financial data are shared between immunisation ICC partners at the national level, information on most partner resources at the provincial and health zone levels is lacking.

Overall Expanded Programme on Immunization

The 2008 Annual Progress Report (APR) estimates that the financing gap of the DR Congo EPI is approximately US\$ 26.8 million in 2008. The APR also mentions that EPI partner (donor and NGO) contributions cannot be correctly estimated, as there are no centralised donor fund mechanisms that allow proper monitoring of the funds provided. What is certain, however, is that the EPI Programme is having difficulty raising national funding for the programme, and it is only through stop-gap measures by UNICEF, WHO, *Santé Rurale* (the Rural Health Programme of DR Congo [SANRU]), and other donors that the EPI programme continues to provide immunisation services in many health zones. DR Congo is also struggling with the end of their ISS funds. This has resulted in operational problems for immunisation service delivery and continued stagnating

²⁵ WHO Health Sector Assessment 2008.



or falling coverage. Basically, DR Congo, like many other countries, has used ISS as a stop-gap and has not ensured cost-sharing or sustainability.

Civil society organisations - historical perspective


From the late 1980s until 1997, DR Congo (then Zaire) suffered from neglect of health services under Mobutu's leadership. This was exacerbated by the war and continuing conflict since 1998. As a result, many areas in DR Congo have virtually no infrastructure, continued unrest, and a majority of the population living in extreme poverty. However, the country's constant CSO presence, both in the form of humanitarian aid and missionary organisations, since the 1970s has helped to address some service delivery gaps in light of poor public sector programmes. Providing any health services in DR Congo is a monumental challenge for the MoH. Under the auspices of the MoH's plans to strengthen the health system in 2006, the government revitalised its health zones (equivalent to districts in other countries). The GAVI health system strengthening grant,²⁶ which is designed to strengthen the human resource pool and infrastructure in 65 largely lower-performing health zones (i.e., districts), together with its civil society organisation grant, has been able to strengthen cooperation between the MoH and its NGO partners, who are the primary service delivery providers in the country.

CSO outreach is critical

In 2001, the number of health zones was increased from 306 to 515. The country currently has 515 referral hospitals, one for each zone, and over 7,725 sub-district health centres. The government has also recently developed a strategy to convert the 11 administrative provinces to 26 regions; however, this is not yet functional. The addition of the new health zones was primarily to increase geographic coverage of referral services and health system management, as each health zone is to have a referral hospital and zonal medical office. Because of the lack of government financing, the health zones and facilities operate with considerable autonomy, although MoH structures have retained administrative control, particularly over human resources. Many facilities became *de facto* privatised, relying on patient fees to pay staff and operating costs. Estimates are that one third of facilities are operated by CSOs, mainly missionary groups, which have traditionally worked in direct partnership with the MoH structure. This has facilitated relationships between the ministry and NGOs for financing personnel and operating costs, particularly at the health zone level.

These CSOs have increasingly assumed an important role, given their consistent presence in the area, relationship with the communities, and the government's

²⁶ For more information, see the Democratic Republic of the Congo's HSS proposal: http://www.gavialliance.org/resources/Congo_Dem_Rep_HSS_Proposal_en.doc



instability and/or lack of resources for health and development over the last 30 plus years. In addition to international NGOs, important partners supporting the implementation of the national health policies at the peripheral level are missionary-affiliated.²⁷

In order to coordinate this vast number of peripheral facilities, the public sector works in partnership with CSOs, based on what these organisations offer in terms of support for materials, medicine, infrastructure and personnel. CSOs provide a range of support, including:

Building/equipment infrastructure (recurrent costs covered by hospitals and health centres);

- Materials (cars, motorcycles, medical equipment, infrastructure, furniture/equipment);
- Consumables such as essential medicines; and
- Personnel that enable the operation of the referral hospitals, the central hospitals, health centres and other referral centres.

Their resources come almost exclusively from finances by international (affiliate) churches, locally generated funds, and associated international non-governmental organisations (INGOs) (e.g., IMA SANRU for ECC and Catholic Relief Services [CRS] with the Dioceses offices of medical works²⁸ [BDOM]). These organisations are very structured and hierarchical. Even if they are on the periphery, the financial decisions always come from the central administrative level of the church. These churches and missions have played a critical role in health care.

Secular CSOs have also played an important role in DR Congo. In some cases, national secular organisations have been extensions of international entities; for example, Red Cross of the DR Congo (CRDRC), Rotary Clubs of Congo (ARCC). International organisations such as Doctors without Borders, Memisa and OXFAM also support the health zones. There are other registered local NGOs that are legally recognised by the government though they have no external partners and their activities are limited.

These various NGOs collaborate with the MoH to help design and ensure that the basic package of health services is delivered. NGO partnerships, through government contracting, have helped to increase immunisation coverage rates (DTP3 and measles).

²⁷ Catholic – through their diocese offices' medical works (BDOM); Protestants – organised through a partnership called Protestant Churches of Congo (ECC); more modest support - from the Kibaguistes churches and the Christian Revival.

²⁸ *Bureaux diocésains des oeuvres médicales*



IV. The GAVI CSO grant proposal and application process

CSOs and particularly service delivery NGOs have customarily been a strong element in the organisation of the DR Congo health system and are critical in the provision of Primary Health Care (PHC). NGOs are present at all the levels of the health pyramid of the country. At the peripheral level (e.g., facilities), NGOs manage and/or support health facilities with 2006 annual estimates of NGO service delivery at 70%²⁹ ; they also carry out community mobilisation, nurse trainings in their medical schools and interventions during health emergencies. At the intermediary level, NGO facilities work in collaboration with the intermediary level of the MoH to plan, jointly manage and monitor the implementation of programmes at the level of the health zones. At the national level, NGOs are members of various bodies affecting health policy and health system strengthening initiatives; they sit on various committees and participate in meetings organised by the MoH.

Prior to initiation of the grant application and selection process in 2007, the partners—primarily WHO, UNICEF, and the United States Agency for International Development (USAID)—all played a part in clarifying what should be done by CSOs versus what the roles and activities of the government would be. For example, the role of CSOs in outreach and service delivery in remote hard-to-reach areas was particularly emphasised.

CSOs and their funding for health zones were mapped under the GAVI Type A funding and were taken into account for the development of both the HSS and the CSO Type B proposals. The proposal development process was unique in that it was jointly led by the the Department of Planning (DEP) in the MoH and three CSOs that have been involved in immunisation programme support and with the ICC in DR Congo: SANRU, CRS, and Rotary.

The CSO selection process was based on prior collaboration with the government. Grants were essentially sole-sourced to a handful of strong CSOs, among them SANRU, ARCC, CRS, CRDRC, and National Council of Health NGOs (*Conseil National des ONGs de la Santé*, CNOS). It was agreed that the CSOs would divide activities and funding based on their previously existing coverage areas in 16 health zones. CRDRC and CNOS undertook cross-cutting issues related to advocacy and information, and education and communication (IED) across all geographic areas, while the other organisations provided direct services in each of their designated zones.

²⁹ GAVI Annual Progress Report 2008


In particular, the CSOs highlighted the challenge of providing coverage for health zones that did not have CSOs with international funding. In order to be eligible to receive the GAVI Alliance CSO funding, there was a pre-condition that the organisation have an international partner, but in some zones there was no international presence. This might not be the optimal use of all CSO resources in the country, particularly of the local CSOs with close community relationships.

CSO Perceptions of the Selection Process

“While it is clear that in DRC the CSOs are recognised by the government as having a vital role to play, it is the churches and mission organisations that have provided reliable and on-going support to the country during the war. This long-term financial and human resource support has been a very visible and tangible presence in the health zones and centres. The churches and mission groups are both recognized and trusted by the government. In the CCIA (Interagency Coordinating Committee) for EPI, for example, the ECC has participated in an on-going and dependable manner. Other INGOs, with the facility of their external resources and because of their presence at the district health level, can also access the table but they don’t feel the same level of commitment. In fact they are often absent. Some of the local Congolese CSOs in partnership with other INGOs (for example Rotary and Red Cross) also have access to decision-making through the ICC and the EPI due in large part because of their presence on the ground. Many local organisations that are not in partnership with large donor agencies are left out and because of this, their actions are limited.”
Medical Doctor, DR Congo CSO community

While the strongest most outspoken CSO contacts felt that the process was open and accessible, some stakeholders felt it was less democratic than had been originally planned. For example, AXxes (a USAID-funded health project managed by SANRU and partners) was selected to participate in the application process. AXxes, which works with ECC and USAID among others, was well positioned and able to mobilise a lot of resources and staff. In addition, because the process originated in Kinshasa, CSOs that did not have representation in the capital were not well represented in the application and selection process.

On the one hand, some of the CSOs felt that they contributed significantly to the mapping of process under Type A funding, meetings of the technical secretary of HSS, annual review and quarterly meetings at central and district levels, introductory workshops and the application and selection processes, while others felt that their potential contributions to improved child health and immunisation outcomes and to HSS were underappreciated.



In contrast, one of the GAVI Alliance partners in-country noted that all stakeholders were not well represented, and that "...GAVI could improve [the process] by increasing communication with CSOs in order that more of them have greater or equal chances to participate; this may require more capacity-building and sensitisation activities with some NGOs to help them better know how to participate." According to one of the GAVI Alliance partners interviewed in-country, the previous selection was less democratic due to weak communication and outreach to the CSOs. There was a delay in carrying out the mapping exercise, so in order to not delay implementation a decision was made to work with the stronger, more readily available CSOs, those that were very much already 'at the table' and known to people in Kinshasa and foreign donors. The more remote, smaller NGOs have not had access to international funding mechanisms in the past and have very little access to funding. However, it is precisely these local NGOs which have good relationships and access to remote communities that would be important to utilise in order to increase immunisation coverage.

The mapping exercise that was planned to help select the Type B funding had set aside US\$ 100,000 during the first phase, and there were 448 CSOs that were identified. A meeting was held the first week of October 2009 in order to provide further clarity regarding the CSO selection process. Consensus was reached that additional CSOs should be included as eligible for the CSO grant. Consequently, among those which were included were ARCC, BDOM, Red Cross, ECC, and CNOC, with numerous sub-grantees (as outlined in the 2008 APR).

V. The GAVI CSO grant implementation process

The CSO grant project³⁰ strives to:

- strengthen the capacities of the local organisations involved in community sensitisation and provide support to primary health facilities;
- train and guide community "bridgers" whose role is to reach the most difficult-to-reach populations;
- provide technical support to the Health Districts (training, high-level supervision, etc.);
- ensure the logistics system of the Health Districts (cold chain and transport);
- provide bonuses to increase staff motivation; and
- organise grassroots support for Health Districts and Centres in their various activities (enumeration, micro planning, advanced strategies, supervision, monitoring, immunisation accelerations and operations research).

³⁰ CSO type A and B US\$ 5,318,520 (2008-2009)



The implementation of this project covers three strategic themes:

1. the five elements of the Reaching Every District (RED) approach in operating health areas (good resource management and micro-planning, advanced activities in health areas, on-the-job training, monitoring for action, and strengthening links with the community);
2. immunisation acceleration activities for non-operating health areas or health areas with very low vaccine coverage; and
3. promotion of integrated child survival activities.

A total of US\$ 5.3 million covers implementation activities under the CSO grant for a two-year period (US\$ 2,988,542 for the first year and US\$ 2,329,977 for the second). The first year of CSO funding was received and disbursed in 2008. The initial grant activities were linked to the HSS window and planning. The grant was managed by a consortium led by SANRU. Each CSO is managing the implementation and tracking of its own grant funds, with the SANRU CSO serving as the consortium lead for the collection and compilation of summary reports to the GAVI Alliance. CSO grantees for 2008 are part of the ICC and include:

- Association of Rotary Clubs of DRC (ARCC) (Association des Rotary Clubs du Congo)
- Rural Health Project, Christian Churches of Congo, administered with Inter- Church Medical Alliance (SANRU/ECC)
- Catholic Relief Services (CRS)
- National Council of Health NGOS (Conseil National des ONGs de la Santé)
- Red Cross of the DR Congo (CRDRC) (Croix Rouge de la République Démocratique du Congo)

ARCC, SANRU and CRS implemented vertical activities, each in different geographic areas, while CNOS and CRDRC were responsible for cross-cutting activities, including advocacy across geographic areas.

Due to the weak public health financial and administrative infrastructure, the CSO funding comes from GAVI directly to UNICEF and the EPI account. The funds are then transferred to SANRU as the CSO consortium lead, and a fixed percentage is distributed to each of the partners based on the number of health zones and the agreed-upon costs of the activities. Based on discussions and interviews with a variety of stakeholders in-country, the CSO grant is seen as being very well run, with streamlined implementation. In particular, stakeholders praised the transparency of the process of grants to the CSO recipients, the actual burn rate of funds, and the reporting of activities and progress.

Although the CSO grant funding was disbursed relatively quickly (in comparison with other grants in the DR Congo, such as the HSS), stakeholders from the CSO

community mention bottlenecks and delays in funding to the CSOs. “The flow of funds remains a huge challenge for implementation. The first tranche of funding was received with a six-month delay. The second was not received until the activities were already being executed. The question is to know if GAVI could fund the CSOs directly.”

Interviewees also mentioned other examples of good collaboration between the CSOs and the Provincial Inter-Agency Coordinating Committee (ICC), citing efforts between the MoH and CSOs to work together to harness the GAVI HSS funding in order to expedite implementation. One CSO mentioned that there is pre-financing of activities for development in health zones that should have received support from GAVI under HSS. This collaboration took place throughout the country.

Implementation progress to date


The five CSOs (Rotary, CRS, ECC, Red Cross, and CNOS) which received grant funding organised themselves into a consortium with a coordinating unit referred to as the COP (Chief of Party) and have been able—despite the delay in the start of activities—to achieve the majority of the principal activities planned in the first year (see Application form C, Section 4, Major activities), including:

- **Support for local census and micro-planning;**
- **Training of Health Zone personnel in EPI management (Health Zone Management Team and Health staff) and in Data Quality Self-assessment;**
- **Supply of transport, gas, and kerosene for the cold chain;**
- **Administration of performance contracts for the health zone personnel;**
- **Identification and training of local CSOs, community mobilisers (“relais communautaires”) and Red Cross volunteers; and**
- **Support for supervision and monitoring of activities in the health zones.**

Results:

- **80% planned activities conducted (despite 6-month delay in receipt of funds);**
- **New management consortium formed and functional;**
- **Vaccination coverage of 74% for DTP3 and measles, 71% for TT2+ from the first half of 2007 for the 65 health zones increased to 83% for DTP3 (close to the 85% defined in the cMYP 2005-2009), to 79% for measles and 76% for TT2+ in 2008 despite strikes and numerous vaccine stock-outs; and**
- **Effective implementation of a strategy for reducing drop-outs through use of community mobilisers (“relais”) and Red Cross volunteers, resulting in 10,613 children recuperated from May to December 2008.**

Source: Excerpted and translated from the DR Congo 2008 Annual Progress Report to GAVI



The Minister of Health put out a request to CSOs and signed a Memorandum of Understanding with the CSOs to participate in the HSS activities. A number of contracts will soon be signed between CSOs and the Fiduciary Agency hired by the MoH which will be responsible for designating CSOs as recipients of the GAVI HSS funding at the Health Zone level.

Contextual socio-political challenges such as strikes and political and social unrest are not unique to fragile states, but tensions may heighten the influence they have on actual grant implementation timelines. For example, a large health care worker strike affected three provinces and was quite damaging during the second window of funding in the first year. Some zones went for three entire months with no vaccinations, resulting in unimmunised children and delays with the grant implementation schedule.

According to one of the CSOs interviewed, human resource management is a difficult problem to deal with since the Health Zones are state institutions. The Health Zones identify the Chief Medical Officers for the zone and other personnel and the CSOs provide resources and accompany said personnel in their work. When strikes occur as a result of failures of the State to provide sufficient pay, CSOs have difficulty ensuring that services are delivered to the population.


Grant oversight, monitoring and reporting

The grant oversight, monitoring and reporting process was integrated into existing structures, but new oversight bodies were created and the perception is that the process has improved over time. The ICC meets once a month with the 16 Health Zones which receive CSO funding both at the central and district level. Together with the National HSS Pilot Committee (CNP) and partners, the ICC provides the oversight of the grant. There are ongoing communications—particularly reports, memos, telephone correspondence, field visits and monitoring meetings—between the partners, including the health ministry and CSOs in the field.

For the first year of implementation the CSO consortium met monthly, and the meetings were facilitated by a Chief of Party (COP SANRU). All five consortium members send reports to the COP every

New systems were developed to monitor and track progress to meet GAVI requirements
“We felt this was necessary. In fact, certain project indicators couldn’t be easily followed with the traditional monitoring tools. It was indispensable to elaborate tools for collecting statistics that could allow for monitoring all the indicators required by GAVI. That seemed to create extra work for the field agents but there was no other way around it.”
CSO Representative

quarter; the reports are compiled and then sent to the CNP. It is noteworthy to



mention that the formation of the consortium has been a huge value-added of the GAVI CSO grant process in helping to solidify coordinated planning, collaboration and outreach amongst those partners.

CSOs send their financial reports and receipts to SANRU, which incorporates them into quarterly and annual reports. For monitoring of the CSO implementation, EPI indicators are being used as well as communication and other locally defined indicators. These are linked with existing reporting systems and indicators that SANRU and the CSOs use in addition to internal and external project-related audits.

The GAVI Alliance grant built in mechanisms in order to ensure good governance. One of the CSOs remarked that, “on the financial end, external audits were received like indispensable tools for the improvement of financial management. Financial procedures were established and were followed. Many activities were brought forth for the purpose of improving the quality of the data, a little like if one waited for an eventual audit of the quality of the data. The data collection tools for the reports were elaborated in relation to the monitoring indicators for the project

VI. Findings


The GAVI Alliance CSO Type B support strengthened cooperation between the MoH and CSOs and increased civil society’s capacity to network and build the CSO consortium. The GAVI Alliance CSO support led to the involvement of 14 additional CSOs that previously had not been involved in immunisation at all.

Support to CSOs in post-conflict or transitional states is essential for immediate and effective implementation to take place on the ground. The model used by GAVI to provide support to DR Congo through CSO grants is a particularly effective way of doing business in fragile or post-conflict states.

Although implementation of the HSS grant was significantly delayed while a

“Because so many of these local organisations have been neglected, while a relatively few organisations have been at the table with the MOH, the government has a hard time reaching populations who are hard to reach. Those groups might otherwise gain access to health care via locally based organisations. For example, displaced Angolans were cited as one group that are neglected but might be reached with support of (other) CSOs that would serve marginalised groups out of concern for human rights or other special interests.”

public sector financial management unit is being put into place, the CSO grant got off the ground quickly. The grant was channeled through established, well-organised CSOs that formed and established a network that



then issued sub-grants to other NGOs for implementation. Several stakeholders reiterated the value of the formation of the CSO consortium as an effective model for rapid implementation to get services to the population as efficiently as possible. This has resulted in significant achievements within the first year of implementation, as seen in the DRC 2008 Annual Progress Report (see excerpt in box above).


That said, there were some significant misunderstandings and bumps along the way during the initial workshops, application and selection processes, which some stakeholders felt could have been more inclusive and participatory in nature. A number of CSOs felt that although the relationship between the government and the CSOs has been strengthened at the central level through the GAVI Alliance CSO Type B funding, this has not consistently been the case at the provincial level. One CSO felt that although “the government invites us to planning meetings and strategy meetings with the ICC; these sorts of things should still be improved at the provincial level.”

The selection of CSOs was neither competitive nor impartial because full HSS mapping had not been done and CSOs were selected based on size and reputation. Other CSOs might be encouraged to apply, but too broad a participation will present a challenge for coordination. Although the participation was narrow, the coordination was good, and the process of harmonising reporting, administrative and logistic procedures took less time than it might have.

VII. Recommendations and lessons learned

The role of CSOs in post-conflict situations needs to evolve as partnerships between the State and CSOs are formalised. One of the main challenges for Ministries of Health and for CSOs is the transition from humanitarian and emergency programming to development and sustainable recovery. This is further complicated by continued unrest in many post-conflict or fragile states, including DR Congo.

CSOs in fragile states have an important role to play in both outreach and service delivery over the short to medium term, as has been demonstrated in DR Congo (for example, Rotary, SANRU and CRS have shifted or extended their presence to some health zones recovering from the war). As fragile states transition to become more solidified, and state confidence and capacity are strengthened, CSOs will need to rethink their strategies to ensure alignment with, and support to, state-building. This new role for CSOs strikes a delicate balance between alignment with Government policies and systems and an independent outside “civil society role,” which is essential to promote legitimacy and confidence in the



state as well. It is also important to point out that while the government may depend in large part upon the CSOs for outreach and health service delivery, there is still a great deal of work and capacity-building to be done to ensure long-term impact and sustainability.

In the future, there should be more attention paid to stakeholder participation, particularly those located in the field in the health zones and participation by Congolese CSOs. In order to rapidly provide funding to CSOs in a fragile or post-conflict state, it is sometimes easier to sole source to strong international organisations already receiving foreign assistance. However, attention needs to be paid to the political burden that may occur if the government and the donor do not include stakeholders at the local District level and from national organisations from the beginning. Along those lines but in a different vein, stakeholders felt that community mobilisation and communication were undervalued during the application process. CSO stakeholders recommended that community-level meetings should be held and these should be funded throughout the process.

It is particularly important for fragile states to recognise the importance and role of CSOs and ally themselves with CSOs through formal partnerships during political or social unrest (e.g. strikes or uprisings) and for longer-term sustainability and service delivery (e.g. in areas where government services are weak or unavailable). The GAVI CSO grant has helped tremendously in DR Congo for this partnership to solidify and for information to flow between CSOs and the MoH. During health worker strikes, the CSOs were able to offset some of the negative effects thanks to CSO vaccination efforts and outreach. Similarly, the long-term CSO presence in some zones enabled rapid implementation of CSO funding.

The CSO grant experience and the ICCC model should be adapted and applied to other countries. The CSO grant experience and the DR Congo's provincial immunisation model provides an example of how funding can flow to the field in a highly decentralised setting. DR Congo has a long tradition of using NGOs to support and provide health services to health zones, and there are a number of lessons that can be learned from this experience, both in terms of financing models to the local level (health zones) and actual implementation. The Inter-Agency Provincial Committees were created for the EPI and although they are not yet functional in all provinces, their model is an effective one.



Annex I: List of documents reviewed

The GAVI Alliance Health Systems Strengthening Tracking Study (Rudolph Chandler, Lori Shimp, Patrick Kalambayi Kayembe, Jean Nyandwe Kyloka) September 2009.

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Annex II: List of interviewees

Dr Valentin MUTOMBO
Rotary /ARCC
Dr Albert KALONJI
SANRU

Dr Adrien N'Siala Kumbi
SANRU/AXxes

Marie - Adèle MATINGU
GIBS (inter-donor health group)

Médard Kikuma Moke
Programme Communication Specialist, UNICEF

Twahiru Yuma
Medecin, Croix Rouge

Yolande Vuo Masembe
RED focal point, WHO

Thomas Monique
Health Coordinator, CRS

Liliane Diat
CSO SANRU-ECC

Lora Shimp, Senior Technical Officer
John Snow Inc.

Michel Othepa, Technical Officer
John Snow Inc.



Case study 3: Ethiopia


I. Overview of GAVI funding windows and support

GAVI Alliance has supported the immunisation programme in Ethiopia since 2001, with total support equaling over US\$ 41,100,819. Ethiopia has received several GAVI grants, including **new and underused vaccines support (NVS)**. As of 2007, the GAVI NVS had been used to purchase US\$ 39,658,723 worth of new vaccine. However, there was a US\$ 9,318,455 gap in funding due to reduced contributions from outside sources. The GAVI Alliance's **health system support** has achieved almost all targets set out in the proposal. The 2009 study on health system strengthening for Ethiopia reported that by bringing services closer to the community, the large-scale training and deployment of Health Extension Workers (HEWs), construction and equipping of health posts and upgrading of health stations have the potential to bring about significant improvements in coverage and the use of proven interventions. Managers interviewed at the regional, zonal and *woreda* (administrative unit) levels expressed certainty that these activities were already contributing to improved health status. Ethiopia's **injection safety support** ended in 2007; support for the programme has been taken over by the United Nations Children's Fund (UNICEF) and the World Bank.

II. Methods – Key informants and study limitations

The first phase of data collection for this case study was to conduct a literature review on all documentation relevant to the GAVI Alliance CSO grant, other GAVI Alliance support, HSS work in country, all GAVI Alliance and task team trip reports and notations, and literature on Ethiopia.

A semi-structured interview was carried out with key informants with knowledge of and direct experience in country. A list of interview questions was shared with those to be interviewed, and follow-up phone interviews were conducted. Key informants included, but were not limited to, the following: coordinating body members—CSO consortium or umbrella group; CSO groups involved in the consultative and application processes; Health Sector Coordinating Committee (HSCC) and/or Interagency Coordinating Committee members; FMoH staff from the EPI and/or Division of Child Health or/and Division of Planning; and GAVI Alliance partners in country, such as the World Health Organization (WHO) or UNICEF.



The main limitation of this study is that due to the short time frame involved for data collection, it was not possible to travel to the country and meet face-to-face with those involved in the GAVI Alliance CSO grant application or implementation.

III. Country context


With a population of 73.9 million, Ethiopia is the second most populous country in Africa. Its annual growth rate is 2.6%, and its population increases annually by 2 million persons. Located in the Horn of Africa, Ethiopia is one of the least urbanised countries in the world, with 84% of its people living in rural areas. The Gross National Income (GNI) per capita stands at US\$ 220—far below the sub-Saharan average of US\$ 952. Nearly 4 out of 10 (39%) Ethiopians live below the international poverty line of US\$ 1.25 per day.

A federal government structure was created by the new Ethiopian constitution, introduced in 1994. The federal structure is composed of nine regional states and two city administrations. These regional states and city administrations are further divided into 810 *woredas*, which is the basic decentralised administrative unit with an elected administrative council. *Woredas* are further divided into units of dwellings commonly known as *kebeles*.

Ethiopia's health status is poor relative to other low-income countries, including those in sub-Saharan Africa. While under-five mortality rates are consistently declining, they remain high, with most recent survey estimates placing under-five mortality at 123 deaths per 1,000 live births. Levels of DTP3 coverage have shown a steady increase, with current coverage reaching 73% of the targeted population (surviving infants). However, regional disparities are wide, with the Somali and Gambella regions reporting DTP3 coverage rates of 15% and 35%, respectively.

Policy and planning

The Central Joint Steering Committee (CJSC) is the highest policy and decision-making body in the health sector and oversees the Health Sector Development Programme (HSDP). The CJSC also coordinates the Health Service Extension Programme (HSEP) and HSS. The CJSC—which is officially chaired by the Minister of Health and is composed of a rotating chair from the Health Population and Nutrition (HPN)-Donor Group (co-chair), Ministry of Finance and Economic Development (MOFED), WHO, the World Bank, USAID, an elected member of the European Health Partners and the Christian Relief Development Association (CRDA)—has overall responsibility for GAVI HSS annual plans, budgets and quarterly progress reports. The Policy Planning and Finance Directorate General (PPF-GD) of the FMOH serves as the secretariat to the CJSC. A Joint Core



Coordinating Committee (JCCC) functions as the technical arm of the CJSC and also provides technical support to GAVI HSS project activities. There are many international groups supporting immunisation and maternal and child health programmes in Ethiopia, among them UNICEF, WHO, and bilateral development agencies from Italy and the Netherlands.

Health sector reform

The Ethiopian Government has made health sector reform a priority. The health component of their overall development plan is the Health Sector Development Programme (HSDP), which the government has been implementing since 1997. As a continuation of the Health Sector Development Programmes—HSDP-I (1997/98 to 2001/02) and HSDP-II (2002/03 to 2004/05)—the health ministry is currently implementing HSDP-III from 2003/04 through 2009/10 (EFY 1998 through 2003).


The ultimate goal of HSDP-III is to improve the health status of the Ethiopian people by providing adequate, optimum and quality promotion, preventive, basic curative and rehabilitative health services to all segments of the population.

A significant policy influencing HSDP design and implementation over time is that of decentralisation, which provides the administrative context in which health sector activities take place. Decision-making processes in the development and implementation of the health system are shared between the Federal Ministry of Health (FMOH), the Regional Health Bureaus (RHBs) and the *woreda* Health Offices. As a result of recent policy measures taken by the government, the FMOH and the RHBs are directed to focus more on policy matters and technical support, while the *woreda* Health Offices have been directed to play the pivotal role of managing and coordinating the operation of the primary health care services at the *woreda* levels. The Health Service Extension Programme (HSEP) is the key mechanism to deliver preventive and some curative services to 85% of the population as one of the goals under HSDP III. Health Extension Workers (HEWs) are the backbone for implementation of the HSEP.

Overall Expanded Programme on Immunization (EPI)

The Expanded Programme on Immunization was introduced in Ethiopia in 1980 with the goal of increasing immunisation coverage by 10% annually and reaching 100% coverage in 1990—a goal that has not been achieved. The current long-term goal of the FMOH's EPI Strategy is to achieve 95% DTP3 and measles coverage by 2009. By 2007, only 32% of *woredas* report DTP3 coverage greater than 80%. The FMOH's Family Health Division and Interagency Coordinating Committee (ICC) oversee the EPI programme.

Immunisation programming is challenged by the same set of constraints that impede the implementation of general health services in Ethiopia, including



understaffing and high turnover of staff at all levels, inadequate follow-up and supportive supervision, shortage of transportation, lack of motivation of service providers, poor functioning of outreach sites, and a weak referral system.

Civil society organisations - historical perspective

CSOs have historically played a vital role in the development of Ethiopia's health system, in EPI provision, and within the HSDP as a whole. The primary role of CSOs is to fill the service delivery gaps generally left uncovered by the government health system and, more specifically, the gaps identified in the HSS grant and in the cMYP. For example, immunisation services are only provided in about 70% of government health facilities nationwide, and CSOs are helping to fill those gaps. Although GAVI HSS support has been important to the further development and strengthening of Ethiopia's health sector, the focus of these funds has so far been mainly on the FMOH's role.

In Ethiopia, CSOs have played a role in training HEWs and District and Regional Health Officers; helping raise awareness in communities through producing and disseminating Information, Education and Communication (IEC) materials; conducting research and gathering baseline information; conducting Monitoring and Evaluation (M&E) activities; and, in extreme cases (such as that of the Pastoralist development association, Afar), providing direct immunisation services to hard-to-reach populations, especially semi-pastoralist and pastoralist, where the State apparatus has difficulty reaching all communities. CSOs in Ethiopia are able to provide direct immunisation services to hard-to-reach populations and semi-pastoralist (i.e., hard-to-reach populations who are in a sense vulnerable and a type of ethnic group or are nomadic) and pastoralists, the only CSO among the grantees that gives immunisations. CSOs are in a unique situation in that they are able to effectively work within the community to provide health services while “working within the culture of the people.” CSOs have a presence at the national and sub-national levels all the way down to the *woreda* and *kebeles* levels.

IV. IV. GAVI CSO grant proposal and application process

Under the GAVI CSO grant, CSOs will provide services in a country's facilities where public sector immunisation services do not reach (approximately 30% of the population).

The consultation process

The GAVI CSO application process began in May 2007 in Ethiopia with the receipt of GAVI CSO guidelines and discussions with the ICC. Later in the year, a

series of meetings were held with the FMoH (specifically, the PPD, Family Health Department, UNICEF, WHO, the World Bank, and CDRA (an umbrella organisation with a membership of over 300 registered faith-based, national, and international CSOs and NGOs in Ethiopia). The team also held a joint meeting with the JCCC and ICC and met with the Health Population Nutrition group of the Development Assistance Group (DAG).


Workshop Objectives

- **Ensure CSOs understand the context for the support: the national immunisation and HSS plans;**
- **Provide a platform for dialogue among CSOs and between the CSOs, the FMoH and its development partners to discuss reasons for low coverage rates;**
- **Familiarise CSOs with the types of support available from GAVI, including objectives and implementation mechanisms; and**
- **Reach a common understanding between CSOs and the FMoH on how to implement the GAVI CSO grant.**

The initial introduction to the CSO funding window was organised to reach a common understanding of how best to work in partnership towards the common goal of increasing immunisation coverage. The FMoH, GAVI Alliance staff and members of the GAVI CSO Task Team created a model workshop to strategically engage and introduce civil society and public sector staff to the new GAVI CSO funding window. The workshop was presented as an opportunity to better coordinate child health and immunisation efforts in the country with some GAVI CSO funding for this work for implementation. The FMoH invited a total of 32 CSOs involved in immunisation, child health and system strengthening to the workshop; 27 attended, including faith-based organisations (FBOs), development

organisations, local and international NGOs and professional health associations. Representatives from FMoH (the Family Health Bureau and the Department of Planning and Programming [DPP]), UNICEF, WHO, the World Bank, the United States Agency for International Development's (USAID) John Snow Incorporated (JSI)/Essential Services for Health in Ethiopia Project and CRDA also participated.

The agenda for the workshop was structured to achieve these objectives (see box) through sessions on immunisation and child health, globally and in the Ethiopian context; the relevant Ethiopian planning frameworks (cMYP, HSS); presentation and group work on the GAVI CSO support and identification of relevant CSO activities; and delineation of practical next steps to take the CSO support forward. The workshop also included creative problem solving as to how CSOs can address identified problems and coverage gaps, including what the CSOs' comparative advantages are to confront these processes and fill gaps.



During the workshop, the CSOs discussed (i) their current activities related to increasing immunisation coverage and improving child health, (ii) what each CSO can do to **overcome the barriers** to immunisation and related health services, (iii) what practical actions each CSO can take to **increase sustained demand** for immunisation and related health services, and (iv) what practical actions each CSO can take to **improve the delivery** of routine immunisation and related health services.

Election of CSO consortium representative

Through a democratic process during the workshop, all of the participants elected CRDA/CORE as the interim representative to the global civil society constituency. The representative was responsible for developing terms of reference (TOR) and, in conjunction with the CSO constituency, worked with the FMoH to develop a TOR for a UNICEF-funded consultant to help set up the process for CSOs to apply for GAVI CSO funding. CRDA/CORE also provided input into the development of Ethiopia-specific guidelines.

Inclusive and participatory process

A second workshop was held in order to ensure inclusion of as many CSOs as possible to discuss the guidelines for application. In addition, the guidelines were widely advertised through newspapers, radio, and TV in several dialects throughout the country, and a deadline for application submission was set. CSOs not able to attend either of the two workshops or which were not aware of this support were notified through email of this opportunity.

A transparent and competitive national selection process

A special session was convened by the JCCC in February 2008 to select the CSOs, using a point system adapted from the INS application screening process. Points were awarded using a weighted matrix system and CSOs were scored based on government and GAVI criteria. This system was devised to ensure transparency in the review and selection process. Considerations included compatibility between the government and CSO in terms of “filling gaps” in the national health system by the CSOs, and whether they have adequate internal financial and management capacity and have worked in hard-to-reach areas. Selected CSOs had to fall into one of four categories: faith-based organisation, development association, professional association or NGO. Another of the selection criteria was that the CSO have an established working relationship with the government. Overlap in terms of geographic coverage was kept in mind during the selection of the CSOs. During the application stage, this was discussed among the CSOs, and although there was regional overlap, there was no overlap among the woredas by the CSOs. It was expressed that overlap and duplication of efforts was consciously avoided during the review of the CSO

applications. Proposals were reviewed by the selection committee comprised of the FMOH, JCCC, UNICEF, WHO, USAID, and the Italian Development Cooperation.

Although the JCCC as a planning body was already in existence prior to the GAVI CSO support, it had two very important roles to play in the CSO selection process: (1) final selection based upon committee recommendation and (2) oversight, together with the PPD, of the entire application process. The JCCC was mandated to ensure that “a democratic and fair process was used in the selection process.”

V. GAVI CSO grant implementation process

The overall objectives of the GAVI Alliance for CSO support in Ethiopia are to increase immunisation coverage within seven regions in the country (Somali, Gambella, Afar, Benishangul Gumuz, Oromia, Amhara and the SNNPR³¹). The focus of the support will be directed to hard-to-reach and marginalised populations. CSOs such as the Afar Pastoralist Development Association (APDA), which works with the one of the most remote communities, purposely chose areas the government is not able to reach to implement EPI in remote communities.

These five selected CSOs in Ethiopia provide a mix of technical capabilities and geographic coverage in the effort to increase immunisation coverage in the country:

1. CRDA,
2. APDA,
3. The Oromia Development Association (ODA),
4. The Ethiopian Orthodox Church Development and Inter-Agency Aid Commission (EOC/DICAC), and
5. The Ethiopian Medical Association (EMA).

Each organisation has its

Christian Relief Development Association (CRDA)

- **Association of NGOs**
- **Faith-based, secular, urban and rural presence**
- **Work in health, HIV/AIDS, good governance, rural and urban development**
- **Over 300 registered CSOs, NGOs**
- **Clearinghouse resource for knowledge management and capacity-building**
- **Member Central Joint Steering Committee (CJSC)**
- **Member of Interagency Coordination Committee (ICC)**

own specific objectives; however, the way they were selected ensures that duplication is minimised. A summary of selected objectives for each of the CSOs can be found in Annex I.

³¹ Somali, Afar and Gambella have the lowest vaccination coverage rates in the country.



HSS complementarity


All GAVI CSO recipients have included a component in their work plans to train health workers or clergy in an effort to build skills in providing health or immunisation services. The application process accounted for complementarity with the HSS and cMYP and was part of the selection criteria. Under the HSS support in workforce, mobilisation, distribution, and motivation” objective, there are a number of activities to expand the number of health workers and motivate them.

Under the CSO grants, there will be refresher training of over 25,000 HEWs, plus an apprenticeship programme for over 12,000 HEWs, 5,400 health centre staff trained in Integrated Management of Neonatal and Childhood Illnesses (IMNCI), and refresher training of 7,400 *woreda* and Health Centre Management Teams. Activities will also include training of traditional birth attendants, community-based reproductive health agents, immunisation practices of health workers, and EPI coordinators on mid-level management and immunisation practices, as well as training clergy to include the referral of immunisation and health services of mothers and children. By the end of 2011, an additional 13,700 persons, ranging from health workers to clergy, will have additional capacity to help meet the HSDP targets. The activities were designed to extend the reach of EPI services to places the *woreda* Health Offices are not able to reach.

There are seven NGOs forming the CORE group under CRDA who will be implementing the CSO funding support. CRDA will contribute to achieving the Millennium Development Goal (MDG) 4 and the cMYP to reduce childhood morbidity by increasing immunisation coverage among children in hard-to-reach and pastoralist communities in some of the areas with the lowest coverage rates. CRDA will also be carrying out a number of activities to improve management capacity at the district and health facility levels and immunisation awareness-raising activities.

Reaching the most difficult to reach

APDA has been working closely with the RHBs on conducting health modelling programmes that will build on an already established relationship with the regional government. APDA's mobile primary health strategies and education delivery practices to Afar pastoralists have been adapted for use by the regional government. APDA has facilitated meetings between the community and the regional government and has provided cold chain equipment to the government. Under the GAVI CSO grant, APDA will employ their “proven practices” used over the last 12 years to provide community and primary health services to the most remote communities in the Afar region, notably pastoralist women and children



who reside in inaccessible areas in Afar. The GAVI CSO funds will allow them to expand their immunisation activities that are so urgently needed in most difficult-to-reach areas that health ministry staff is not able to access. To build local capacity, APDA will conduct house-to-house awareness-raising as well as air radio messages to reduce misconceptions and fears of immunisation in the region.


EMA will provide training to health ministry EPI coordinators at the *woreda* level and train health workers on improving vaccination practices at the health facility level, with a focus on the three emerging regions in Oromia and Amhara. Because of the delay between the application submission and actual implementation, and subsequent population growth beyond original projections at the *woreda* level, their main challenge will be to achieve their pentavalent coverage target rates. EMA will be hiring a project officer to manage the GAVI-funded activities as they build their capacity in working in immunisation.

Regional training of trainers

Through the GAVI CSO programme, **ODA** also continues to build upon their good working relationships with the District Health Officers and RHBs. To reduce the number of defaulters (those who do not return for their follow-up immunisations), ODA will integrate their work in reproductive health by recruiting and training Community-based Reproductive Health Agents (CBRHAs), health workers, and EPI coordinators to increase their knowledge of and capacity to deliver immunisations. To do this, they will collaborate with the regional training centres to begin a cascade Training of Trainers process, whereby district health officers, nurses and health officers will be trained at the centres and then provide the same training in their respective districts and *woredas*. For ODA, the addition of supporting immunisation activities is seen as a welcome complement to their organisation. Immunisation activities, which have not been the focus of ODA's work until now, will serve to "strengthen their project and complete the picture of RH activities which is of great help." ODA has completed its project implementation guidelines and quarterly budgets and is ready to begin activities immediately.

Training of the clergy - advocacy and awareness

EOC will train clergy to act as advocates to increase the awareness of vaccine-preventable diseases through focusing on the community, in particular women and children, about the importance of being immunised against vaccine-preventable diseases. A nurse will be trained to help provide supervision of the clergy, and a project coordinator will help manage the GAVI CSO funds and organise these trainings. To create a sustainable initiative, the RHB EPI focal unit person will be invited to participate in the trainings for trainers. This pilot training



of the clergy is one of the first of its kind and, if successful, will be scaled up to the national level.

Coordination and monitoring

Overall oversight and implementation of the GAVI CSO support will be the responsibility of the PPD as they are the coordinating body for the FMoH. The JCCC will provide management and technical assistance, and the ICC will provide oversight of grant implementation.

Visits to the field by FMoH staff have not yet been planned. Although there has been some inter-CSO collaboration between CRDA and EMA, as CRDA is a member on EMA's board, there are no plans as yet for the CSOs to meet on a regular basis, nor is it clear who should be responsible for coordinating these meetings³².


Financial accountability and systems

The GAVI CSO funds are being managed by the MDG performance package fund. The FMoH distributes the funds to each of the CSOs. The funds will be released on a bi-annual basis, with the first tranche disbursed in August 2009.

Reporting systems and data management

The refinement of the Health Management Information System (HMIS) and selection of indicators to measure CSO performance has been an on-going process in Ethiopia. The HMIS will be used as the tool by the PPD to monitor CSO funding support in conjunction with HSPD and cMYP progress monitoring. Indicators to monitor the CSO support originate from the HMIS. The GAVI Annual Progress Report form has been modified to be used for quarterly reporting by the CSOs, who are to report to the GAVI focal point person and the PPD on a quarterly basis using a standard format provided by GAVI CSO. The report will show the percentage of activities implemented and outcomes achieved as well as any issues and monies spent. To track overall CSO progress, the GAVI coordinator, PPD and CSOs will meet on a quarterly basis. Additionally, the Regional Joint Steering committees will meet with the CJSC on a quarterly basis to monitor progress. Since the RHBs will have access to information on CSO progress in their regions and they report to the Regional Joint Steering Committee (RJSC), the CJSC will be able to monitor CSO progress through this forum as well. From the CSO end, CRDA has always conducted routine

³² Because CRDA has experience working both with GAVI grants and in immunisation delivery, EMA has met with them on an informal basis to better understand the grant process as well as implementation in the field. This type of support will continue throughout implementation. APDA is part of the Afar Pastoralist Development Forum, which is a group of CSOs in the Afar region that meets twice yearly.



monitoring and will be working with the local government to enhance the routine monitoring systems in pastoralist areas.

Overall, GAVI HSS support to Ethiopia is US\$ 76,499,935 (2007-2009), and CSO support is US\$ 3.3 million for 2008-2010. CSO grant implementation has just begun for the CSOs, which received their first tranche of funds in August 2009.

VI. Recommendations and lessons learned

The workshop provided a platform under which the government, for the first time, shared with the CSO community more about the country's long-term plans to improve health and child survival through the work of the HSEP under the HSDP and the country's Multi-Year Plan (cMYP). This workshop was the first opportunity for different types of CSOs to discuss among themselves, as well as with the FMoH, their immunisation and related health services. Bringing these stakeholders together is an important result for partnership-building and both political and operational collaboration between the government and civil society.

The GAVI CSO process, which began in May 2007 with an introduction to the FMoH of this new support, is just beginning the implementation stage now in October 2009, nearly two and a half years later. Between

This [workshop] was one of the “first of this kind in Ethiopia where CSOs were involved on a large scale like this. This has positively changed the attitudes of many in the government and it has been good to see the government is channeling money to NGOs for public health work.”

CSO Representative

the submission of the application in March 2008, questions from and response to the IRC, and final approval in November 2008, almost one year had passed since the CSOs submitted their applications. They had planned to begin work by late 2008 but only received funds starting in June 2009. Upon submission of the application, the work plans for each of the CSOs included an anticipated start date of October 2008. Although the process was highly participatory and inclusive in Ethiopia, the time between initial introduction of the grant mechanism and actual disbursement and implementation was rather lengthy.

During the application process, it was noted that many CSOs sought support and technical consultation through both formal and informal channels. In future rounds, it may be more effective and efficient to have a designated CSO coordinator, as other countries have done, in order to provide ongoing, focused technical support during the entire proposal process. \$



Thoughts on the consultative process

Workshop participants stated that the open, participatory and transparent design of this process was most appreciated. The process of developing HSS and CSO proposals provides an excellent opportunity to broaden the discussion and initiate dialogue across MoH divisions and with CSO partners. It is essential to maintain a consultative process with all partners—public sector, CSOs and GAVI Alliance—in designing the workshop and defining how to utilise GAVI CSO support. Investing extra time and effort at the time of the introduction workshop in support of a country-driven effort, especially in countries without long and strong relations among CSOs and partners, will lead to better and more durable returns later.

This workshop modality seems to be an effective and highly transparent vehicle to bring together the different constituencies in a country with a large civil society constituency for open discussions on cMYP, HSS efforts by the government, and collaboration between CSOs and the health ministry. The workshops have also been helpful in ensuring that information is conveyed to the CSOs themselves. Because workshops are good platforms for discussing issues of CSO representation and coordination, as well as for establishing mechanisms to communicate with government agencies, messaging about the objectives of each workshop needs to be developed according to each country's situation and in close collaboration with in-country partners. While a workshop can initiate the collaborative process, the FMoH and CSOs must develop the ongoing mechanisms to periodically share progress, identify gaps, and determine solutions.

Although the consultative process undertaken during the application and proposal development stages in Ethiopia was fruitful, there are still areas that could be strengthened for future consultative processes. Upon grant approval, it would be worth providing an orientation for the selected CSOs to the EPI as some have worked more closely in this arena than others. This would ensure that the CSO grantees receive the most current information on immunisation practices.

Annex III: CSO background and objectives

Ethiopian CSOs, supported by GAVI

CSO	Type	Geographic Coverage	Allocation (US\$)
CRDA	NGO	Gambella, SNNPR, Somali, Benishangul Gumuz	1,715,072
ODA	Development association	Oromia	552,107
EOC/DICAC	Faith-based organisation	Amhara	260,346
APDA	Non-governmental organisation	Afar	232,468
EMA	Professional association	Afar, Amhara, Somali, Benishangul Gumuz, Oromia, SNNPR	211,660

Summary of CSO objectives under the GAVI support

CSO	Selected Objectives
CRDA	<p>Contribute to the achievement of MDG 4 (reduction of child mortality by 2/3 by 2015) and to the cMYP through increasing the number of immunised children in remote, hard-to-reach and pastoralist communities in the country.</p> <p>Reduce DTP1-HepB1-Hib1 and DTP3-HepB3-Hib3 dropout rates by 50% from the baseline by 2010.</p> <p>Increase measles coverage by at least 25% in Assosa, Gambella, Mejenger, Agnuak, Nuer, S. Omo, Shinile, Liben, Afder, Afar Zone 3, Borena Zones by 2010.</p> <p>Increase TT2+ coverage in pregnant women by 10% from 2007 baseline by 2010 and increase by 25% in non-pregnant women in the same time period.</p>
APDA	<p>Improve the current health situation of 40% of the population of Dagaba, Daaba, Kori Zones in Afar; specifically, 'Ada'ar, Goolina, Magaale and Eribte Districts (a total population of 56,517 mothers and children) through awareness raising and routine preventative measures.</p> <p>Improve the nutritional status of the same population through monitoring, screening and providing the appropriate response within the same time frame.</p> <p>Improve child disease resistance in the same areas through de-worming and Vitamin-A supplementation against abdominal parasites.</p>

EOC/DICAC	<p>Increase clergy participation in child survival and immunisation activities.</p> <p>Increase access for women and children to at least 90% in targeted districts to “full antigens” with a maximum drop-out rate of 5%.</p> <p>Enable trained clergy to refer eligible mothers and children for immunisation and health services.</p>
EMA	<p>Reduce morbidity and mortality in under-fives due to vaccine-preventable diseases. This is to be done by providing good quality immunisation services through skilled health workers.</p> <p>Increase pentavalent coverage to above 80% in 90% of its operational districts in the three emerging regions in selected zones in Oromia and Amhara by the end of 2010.</p>
ODA	<p>Improve the health status of mothers and children in targeted areas of Oromia (Jimma, East Wollega, Horo Guduru Wollega, West Wollega, Illuababor, East Harerge, S/W Shoa, Qellem Wollega) through community-awareness activities focused on vaccination and immunisation.</p> <p>Expand immunisation services to 95 Districts in Oromia and enhance the capacity of District Health Officers by training Health Workers at different levels in the 95 project districts.</p>



Case study 4: Pakistan

I. Overview of GAVI funding windows and support

Pakistan was approved for GAVI **immunisation services support** (Phase 1) funds in 2001. To date, the government has received US\$ 10,744,548 in approved funding. As of 2007, the funds were being used to purchase cold chain equipment, fund transportation for service delivery and supervision, purchase office equipment, pay salaries, provide training for supervisors at district levels, and give performance rewards to individual staff of the Expanded Programme on Immunization (EPI). Pakistan has so far received US\$ 104,217,642.

GAVI support through the **new and underused vaccines support** grant in Pakistan began in 2001 whereby the hepatitis B vaccine (monovalent) was introduced in routine EPI in a phased manner. The monovalent hepatitis B vaccine was replaced by tetravalent vaccine in 2006 and 2007, which included DTP and hepatitis B in a combination form. The DTP-HepB vaccine was launched in a phased manner in country, initially being introduced in two provinces in the last quarter of 2006 and, in 2007, fully integrated in country. Pentavalent was the first awarded vaccine to be introduced under GAVI co-financing in July 2008.

The country began receiving money from the **injection safety support** fund in 2003. GAVI provided autodisable (AD) syringes and safety boxes for all EPI vaccines in country through the United Nations Children's Fund (UNICEF) during 2003-2005. The total worth of this support was US\$ 8.67 million. The Government of Pakistan started bearing all expenses from 2006 onward.

The GAVI Alliance Board approved the Pakistan proposal on **health system strengthening (HSS)** in the last quarter of 2007. A two-year proposal totaling US\$ 23 million was approved. The first year's funds for HSS were for US\$ 16,898,500. Under the GAVI Alliance CSO support, 15 CSOs working in maternal and child health all over the country have come together to support the Ministry of Health (MoH) in HSS. Based on their geographical presence, the CSOs have been divided into three geographical clusters, each comprising five to six CSOs with one CSO as a coordinator. The three clusters form the CSO Consortium, which reports to the Technical Working Group (TWG) of GAVI CSO support and to the National Health Sector Coordination Committee (NHSCC).



II. Methods – Key informants and study limitations

The first phase of data collection for this case study was to conduct a literature review on all documentation relevant to the GAVI Alliance CSO grant, other GAVI Alliance support, HSS work in country, all GAVI Alliance and task team trip reports and notations, and literature on fragile states, DR Congo in particular.

A semi-structured interview was carried out with key informants with knowledge of and direct experience in-country. A list of interview questions was shared with those to be interviewed, and follow-up phone interviews were conducted. Key informants included, but were not limited to, the following: coordinating body members—CSO consortium or umbrella group; CSO groups involved in the consultative and application processes; Health Sector Coordinating Committee (HSCC) and/or Interagency Coordinating Committee members; MoH staff from the EPI and/or Division of Child Health or/and Division of Planning; and GAVI Alliance partners in-country, such as the World Health Organization (WHO) or UNICEF.

The main limitation of this study is that due to the short time frame involved for data collection, it was not possible to travel to the country and meet face-to-face with those involved in the GAVI Alliance CSO grant application or implementation.

III. Country context

Pakistan is a Southern Asian country with a population of approximately 161 million inhabitants. In 2007, WHO ranked Pakistan's health system in 122nd place in its list of 190 countries. Its infant mortality rate in 2007 was 78 deaths per 1,000 births. The proportion of deliveries assisted by skilled birth attendants was 30% in 2006³³.

Although the private sector plays a large role in the provision of health care services, preventive health services, including EPI, are almost exclusively provided by the public sector health delivery system. In 2001, there were 541 rural health centres, 879 maternity and child health centres, and 907 hospitals³⁴. Government spending on health is only 2% of total expenditures. Since Government policy emphasises an increase of domestic funding for health, it is expected that the government allocation to health should increase in the near term.

³³ HSS Summary report.

³⁴ Expanded Programme on Immunization Financial Stability Plan.

Overall Expanded Programme on Immunization (EPI)

The EPI in Pakistan was started in 1978 as a continuation of the small pox eradication programme. It currently provides routine immunisation services to children under one year of age and tetanus toxoid (TT) immunisation to pregnant women, in addition to conducting supplementary immunisation activities for polio, measles, and tetanus that target different age groups. As of 2008, 73% of newborns over one year of age had received the DTP3 vaccination. Overall, however, reported DTP3, BCG, and HepB3 coverage has varied over the past five years.

Table 1: Selected Immunisation Indicators for Pakistan³⁵

Indicator	2008	2007	2006	2005	2004
DTP3	73	83	83	80	65
BCG	90	89	89	82	80
HepB3	73	83	83	73	65

There is little demand for immunisation services in remote and difficult-to-reach areas of the country. As a response to this lack of demand, the government is planning to increase its social mobilisation efforts in the form of advocacy meetings, mass media communications and distribution of leaflets to parents.

In selected areas, a few NGOs are actively involved in the provision of EPI services in collaboration with provincial health departments. The role of certain NGOs, especially in social mobilisation activities, has been particularly evident during National Immunisation Days (NIDs) for polio. NGOs are encouraged to assist in EPI activities under the Expanded Programme on Immunization Pakistan Policy and Guidelines.


Table 2: Socio-economic Indicators 2007

Indicator ³⁶	Value
Districts with over 80% DTP3 coverage	25% (2006)
Under-5 mortality rate per 1,000	103
Infant mortality rate per 100	78
Proportion of deliveries assisted by Skilled Birth Attendants (SBAs)	30%
Population	160,943,000

The National Health Sector Coordinating Committee (NHSCC) was created in 2006 to oversee the GAVI Alliance HSS grant. The NHSCC provides programmatic and management oversight and approvals to the HSS grant as well

³⁵ http://www.who.int/immunization_monitoring/en/globalsummary/countryprofileresult.cfm.

³⁶ HSS Summary report.



as some technical assistance. It also helps review the proposed CSO activities to ensure that they are in line with the HSS support.

Civil society organisations (CSOs) - historical perspective

A 2001 survey on civil societies in Pakistan reported that there are 10,000 to 12,000 active and registered NGOs in country, the majority of which (59 percent) are located in Punjab. CSOs are composed of a variety of institutions, including political parties, NGOs, academia, professional associations, trade unions, traditional and non-traditional faith-based organisations (FBOs), and savings groups³⁷. It was also noted that, "...civil society at large are playing a very significant role in promoting individual welfare and collective development through a variety of interventions."³⁸ Although the State appreciates the work CSOs carry out, CSOs can also be perceived as a competitor for donor funding, and they have limited ability to make, change or implement policy because of the political situation in which they operate. There are few instances of active government CSO collaboration.

The GAVI CSO grant provides an opportunity to further strengthen the engagement of the health sector CSOs with the government. CSOs have occasionally worked with the ministry on an ad hoc basis with informal and fairly weak linkages and coordination at both the central and lower levels. The government has always recognised the work of CSOs, but there has always been some tension between the two sectors because of perceived misconceptions. The CSOs see the delays, problems, and staff turnover that stem from the traditional government structures as being at times a hindrance to close collaboration with civil society. The MoH sees the donor money going to the CSOs but cannot demonstrate impact. It also sees that CSOs can be critical of the government's work. These are stereotypical perceptions between the two parties.

The private sector, inclusive of CSOs, provides a large proportion of community health needs in Pakistan. They are positioned closely in communities where public sector facilities such as the Basic Health Unit and the Rural Health Centre are not available. CSOs have the advantage of having gained the trust of the community in remote and very poor communities where the public sector has not been able to provide access to care. Because of historically weak coordination between the government and CSOs, civil society groups have not had or known of opportunities to leverage their capability to generate more demand for health services. Nor have they been able to collaborate with the public sector in order to link up with and further advance the development of the public sector's referral and counter-referral system for clients, particularly for immunisation services.

³⁷ Baig, August 2001

³⁸ Ibid.



IV. GAVI CSO grant proposal and application process

The CSOs' support of, and work with, the government will help increase the CSOs' overall awareness of the MoH's plans to strengthen the system. The following describes the overall proposal and application process that took place in Pakistan.


A TWG—comprised of the National Programme Managers from the Maternal and Child Health Unit, EPI, Family Planning and Primary Health Care divisions, other ministries, UNICEF and the CSO Support Coordinator—was formed to manage the GAVI CSO application and selection process. During the application process, the TWG was responsible for the day-to-day management of the application submissions. During implementation, the TWG will be responsible for reporting to the NHSCC. The TWG met regularly with CSOs during the preparation phase. The three chosen cluster heads are on the NHSCC as representatives of the CSOs participating in this initiative. The government's Planning and Development department, UNICEF, and WHO provided technical assistance during the application phase.

As part of the GAVI Alliance support to CSOs³⁹, an introductory workshop took place in 2007 which was organised by GAVI Alliance partners in-country and led by a CSO support coordinator hired by UNICEF to facilitate the process. The goal of the workshop was to promote communication and collaboration between the public sector (MoH) and civil society and to introduce the GAVI Alliance's new funding modality for partnerships between the MoH and the CSOs. This workshop was catalytic in that it brought together for the first time CSOs working in the Pakistani health sector. Thirty-five CSOs were invited and 23 attended, representing international and local NGOs and MoH officials and managers, UNICEF and WHO. The workshop focused on how CSOs could support the government and on discussions and the exchange of ideas as to how to essentially extend access to health services through the work of CSOs.

For many CSOs, it was a first introduction to the GAVI Alliance. Additionally, the EPI National Programme Manager (NPM) provided an overview of the HSS work to the CSOs, which made critical linkages between system strengthening and improvements and health outcomes, particularly at the primary health care level. This was, overall, an excellent learning experience for the CSOs.

A total of 23 expressions of interest were received from the CSOs after the initial September 2007 workshop. They submitted their proposed objectives, the

³⁹ In November 2006 the GAVI Alliance, under its HSS window, launched a new type of funding to support CSOs.



thematic (technical) and geographic areas they would cover, and the funding required. After the CSO information was received, a mapping process was begun to look at each individual CSO's capabilities and services to determine if there was any geographic overlap. The CSO support coordinator worked on the mapping exercise and also met with each of the CSOs to answer any questions.

Four months later, in January 2008, the CSOs who expressed interest were invited to a second workshop to re-introduce GAVI CSO support, provide an update on the application process, and agree on next steps for the application development process. The CSOs were given the chance to

"This was a very fruitful process as it helped verify the CSO's capabilities and provided support during the process."
CSO Coordinator


present their capabilities and services and to discuss and learn more about larger national health efforts as they discussed how their potential activities would support HSS. It was a good learning process for the CSOs, helping them to understand how some of their work fits within the context of reaching the Millennium Development Goals.

The workshops brought together the MoH and the CSO community to discuss the strengths of the CSOs and to begin thinking how they could best contribute to improving the health system, particularly using the GAVI CSO support funding. It was the first time meetings of this type were held specifically for the purpose of CSOs to work alongside the government and exchange discussions and ideas regarding national level initiatives. It was also an opportunity for the more established CSOs to see how they could network with the smaller organisations.

The GAVI CSO application process allowed a further breaking down of barriers between the CSOs and the health ministry. Because there have been few opportunities for the two to interact, either informally or formally, communication gaps and misconceptions had been formed between these sectors. Previous to the workshops, individual CSOs had only been involved on an informal basis in MoH planning or activities and consulted or invited to meetings occasionally; they were not, however, part of a formal or

"This has been a good learning experience ... to see the good commitment of the CSOs. I am happy that this was not a donor-driven programme. Rather the government utilised the available resources in the country by taking advantage of what the CSOs have to offer to develop the grant proposal."
CSO Coordinator

established consultative process. But in the GAVI CSO process, the CSOs were actively participating from the beginning, helping to decide the proposal process, next steps, deadlines, and formation of the clusters, and this opportunity offered them a chance to actively participate and shape the process.



The application process provided the CSOs with opportunities to make suggestions and participate in the decision-making processes. There was a great deal of satisfaction on the part of the CSOs, who appreciated the respect for and incorporation of their ideas by the government during the planning process. For instance, it was the CSOs who suggested the formation of three CSO cluster groups based on geography in order to create a more manageable structure under the consortium and to have a cluster head coordinator for each group. This organisational structure was approved and validated by the MoH. The newly formed consortium is intended to become an ongoing long-term network of CSOs that will maintain its existence beyond the life of the GAVI CSO grant period.

To operationalise the consortium, a CSO support coordinator was hired to be a liaison and develop the mechanism and procedures to build a partnership with the government. One of the first steps in establishing the consortium was the mapping exercise to document and capture the technical skills, breadth, scope, and geographic coverage of the CSOs. This information will be utilised as well in the form of a CSO database, where additional CSO information will be added to serve as a resource for the ministry's HSS planning and programming.


To assist with the proposal preparation process, the MoH provided the CSOs with background material, including HSS plans, Maternal Neonatal and Child Health Strategic Framework, and other national-level studies. The sharing of the HSS proposal was important in increasing their understanding of system strengthening and to help them prepare their proposals.

The CSO coordinator played a key role in helping the CSOs prepare their individual applications and as a facilitator with the government. The coordinator sat in the EPI office and helped to build confidence in the partnership within the

“Through the pre-proposal workshops and proposal process the government has become much more familiar with the CSOs and the work they do. They have been able to identify which CSOs have been effective, and which ones need more capacity.”
CSO Coordinator

MoH as the application process moved forward, and relationships were further strengthened between the CSOs and Ministry staff.

The CSO coordinator played a key role in many aspects of the process, including working with the individual CSOs to prepare application proposals and facilitating relationship building between the EPI NIH staff and NGOs by holding a series of technical exchanges and discussions. The culmination of the work on relationship building and proposal development was done in an interactive and participatory manner over a six-month period (9/07-3/08). It allowed the government to become more familiar with the CSOs' different skill sets and competencies. The CSOs brainstormed ideas as part of a joint problem-solving



process. Upon review of the proposals, it was discovered there were clear areas of geographic overlap between the CSOs. In order to work towards resolution of this issue, the CSOs were asked to discuss among themselves within their three cluster groups how to avoid this overlap and come to a decision as to where each CSO would work.

Strategic Planning and Geographic Coverage

The CSO Coordinator worked closely with the larger International CSOs, such as Save the Children/UK and the National Rural Support Programme (NRSP), to shift their activities to the harder-to-reach areas not already covered by other smaller local CSOs. These CSOs were asked to re-think their coverage areas since they have more staff and greater flexibility than some of the smaller, less established local CSOs. The final selection of CSOs is a mix of research institutions, service delivery organisations, women-focused organisations, and advocacy and community mobilisation groups representing both international and local organisations operating at all levels (district, provincial and central) of the country.

Some positive changes have already come about as a result of the GAVI CSO process. The CSOs were given the opportunity to present their current work to a wide range of partners, and the TWG, which included members from the MoH and other government, representatives, reviewed the 18 CSO applications. Consequently, the MoH has become much more familiar with and aware of the CSOs' capabilities and skills. As a result of the proposal development and application process, the MoH requested that the CSOs help with other activities outside of GAVI CSO activities. The government conducts polio campaigns and requested their assistance in developing training-of-trainers manuals based on the needs of the ministry's teams. The CSO designed interactive illustrative materials for these teams, and the overall experience was very successful. The CSO has already been asked to help with other future trainings with the MoH.

For some of the CSOs, the opportunity to expand their portfolio, whether managing GAVI-funded activities or working in immunisation for the first time, will help build their overall capacity. It has been expressed that the GAVI-funded activities will further leverage and build the trust of the community.

V. GAVI CSO grant implementation process

The main objectives of the Pakistan CSO proposals are to support and complement the ongoing HSS work in Pakistan, working with the community to access the most difficult-to-reach populations through the network of CSOs in the country. The three objectives to be met under this grant are to:

1. **Improve the quality of Maternal, Neonatal and Child Health (MNCH) services** by (a) equipping and revitalising First Level Care Facilities (FLCFs) through the provision of drugs and equipment; and (b) enhancing the effectiveness of prevention and promotion of MNCH outreach services through the provision of necessary equipment and supplies to Lady Health Workers (LHWs), Lady Health Visitors (LHVs) and Skilled Birth Attendants (SBAs).
2. **Broaden the range of MNCH services** provided at various levels of care by improving, expanding and diversifying the skills of health workers in the private sector at FLCF: LHWs, LHVs and SBAs.
3. **Improve access to the above quality services** by (a) improving referral systems and providing referral support to CSOs, EPI vaccinators, and LHWs and LHVs for child health and maternal health-related activities; and (b) empowering communities and village-based health committees to effectively participate in accessing and monitoring the quality of health service delivery vis-à-vis immunisation and mother and child health care.

These objectives are part of the larger effort of the MoH's MNCH programme in Pakistan. The grant objectives focus on the marginalised and the poorest communities served by the CSOs, which through this grant serve as an extension of the MoH by providing essential services to vulnerable populations. The strategy behind the design of the GAVI CSO activities involves strengthening the provision of basic health care in the community through training community-based LHVS, LHWs, and other health workers.

The first tranche of funds was released in mid-2009⁴⁰. The three CSO clusters are divided based on geographic coverage areas and through the use of a mix of stronger and larger CSOs and smaller CSOs in each cluster to balance the skills and needs of each area. The CSOs will cover all four provinces of the country: Balochistan, North-West Frontier Province (NWFP), Punjab, and Sindh.

Table 3: Pakistan GAVI CSOs

Cluster	Geographical Area	# of CSOs
Cluster 1	Northern Areas, Punjab, NWFP	5
Cluster 2	Balochistan, AJK	4
Cluster 3	Sindh	7

Strengthening relationships and further formalising and acknowledging the roles that CSOs play in the health care arena continue during early implementation. In September of 2009, a Declaration of Commitment meeting was held with the selected CSOs and the MoH's national programme managers, including those from EPI, MNCH, HIV/AIDS, tuberculosis and malaria, as well as the NHSCC.

⁴⁰ The funds requested were US\$ 4,587,000 for two years (2008-2009).

During this meeting, a memorandum of understanding was signed and endorsed by the MoH technical partners, along with UNICEF and WHO. The intent of this memo is to formalise the CSO collaboration with the government.


The launch of the CSO grant included the 15 CSOs which were selected as grant recipients, along with key organisations that were not selected to participate but rather have chosen to work with the MoH and the CSO grant recipients to further the objectives of the grants.

“As another sign of improving relations, by the end of the meeting the district level officials were offering their support to the CSOs to help facilitate activity implementation, an example of the impact of meetings to build trust and relationships.”
CSO Cluster Head Coordinator

The CSOs which are receiving GAVI Alliance CSO support include the following:

1. **Aga Khan Health Services** (Islamabad)
2. **Aga Khan University** (Karachi)
3. **APWA** - All Pakistan Women Association (Islamabad)
4. **BDN** - Basic Development Need (Nowshera)
5. **CHIP** - Civil Society Human and Institutional Development Programme (Islamabad)
6. **HANDS** – Health and Nutrition Development Society (Karachi)
7. **HELP** – Health Education and Literacy Programme (Karachi)
8. **LIFE** – Literacy/Information in Family Health and Environment (Islamabad)
9. **NRSP** – National Rural Support Programme (Islamabad)
10. **PAVHNA** – Pakistan Voluntary Health and Nutrition Association (Karachi)
11. **PRSP** – Punjab Rural Support Programme (Lahore)
12. **PVDP** – Participatory Village Development Programme (Hyderabad)
13. **SABAWON** – Social Action Bureau for Assistance in Welfare and Organizational Networking (Peshawar)
14. **SAVE the Children UK** (Islamabad)
15. **The Health Foundation** (Karachi)

A separate launch was held for the Sindh cluster in August 2009, hosted by the Aga Khan Health Service. During this event, all of the Sindh CSOs and district government officials were invited, and the EPI National Programme Manager and UNICEF staff attended. The group reviewed the milestones that would take place over the life of the grant (18 months). During the Sindh meeting, a suggestion was made to include the basic health unit (BHU) on the health management team since the CSOs will be working hand in hand with the BHUs as part of the management team that will help facilitate grant implementation. BHUs are primary health care facilities that are the first tier in the public health system structure.



Overall, GAVI HSS grant support to Pakistan is US\$ 23,525,000 for 2008-2009, and CSO support is US\$ 4,587,000 over a two-year period from 2009-2010. The work the CSOs will carry out through the GAVI CSO support will complement the training already being conducted by the government to increase the number of community women health workers to become SBAs and LHWs.

Financial disbursements

The transfer of the first tranche of funds occurred without any problems. The next two tranches will be released in six-month intervals (30% and 40%) upon receipt of progress and financial reports, and determination of deliverables against work plans. Once UNICEF receives an authorisation letter from the MoH, the monies will be released.


GAVI had been transferring funds through the government using a special account set up under the Programme and Implementation Cell in the Planning and Development division of the MoH, but this mechanism is no longer ideal so the health ministry asked UNICEF to manage the GAVI CSO funds.

Since the proposals were originally submitted, the economic situation in Pakistan has rapidly deteriorated. Unfortunately, the CSOs were not able to adjust their requested funding amounts accordingly. Many of the CSOs submitted their requests in rupees rather than in dollars, which may present a funding issue due to devaluation of the rupee as inflation escalates.

Coordination, monitoring and evaluation

To keep the CSOs engaged early on, the coordinator sent regular correspondence and information to the CSOs, updating them on the work carried out by UNICEF or other MCH and immunisation topic areas. This correspondence has continued since the start of implementation. The CSO coordinator has played a key role, which can be summed up by one comment, that she is the “engine” that runs the GAVI CSO programme.

As part of coordination and monitoring efforts, the CSO clusters are planning to meet every two to three months or at least once during each quarter to update each other on implementation status and to work together as a team to troubleshoot problems. The meeting location will change each time and be on a rotating basis among the clusters. District health officers will be invited to participate in these meetings in order to ensure ongoing communication and engagement between the public sector and the CSOs. The cluster heads are planning to meet once quarterly with the CSO coordinator; they have met twice since implementation and began to receive funding in June 2009. Additionally, three cluster meetings are planned over the life of the project (18 months) with the TWG, district, and provincial governments in order to monitor activities on a



regular basis. Each quarter, there will be a monitoring field visit at the cluster level by the TWG. The MoH has expressed the desire to visit CSOs in the field. It was noted that these visits will continue to help avoid any misunderstandings between the government and the CSOs.

The CSOs have the support of not only the CSO coordinator but also the deputy EPI manager, who has been designated to work on this CSO initiative. They have been working very closely together and meet on a regular basis. UNICEF has been closely involved as well, offering technical assistance to the CSOs. There are good communications between the CSO coordinator and the CSOs, with the CSOs having access to the coordinator on a daily basis.

An Example of Information Sharing at the District Level: Sindh Cluster


During the launch of activities for the Sindh cluster, it was agreed that a memorandum of understanding between the District Health Office and each CSO *“would be drafted to help open doors and establish a formal relationship.”* The district has also been asked to support the CSO efforts and share data to help measure the impact of the grant activities. In general, written approvals are needed from each subsequent level, the province and federal level, to release data.

Monitoring and evaluation orientations will be held by the CSO coordinator and UNICEF for each of the CSOs to build their capacity in this area. It was noted that many of the CSOs’ proposals’ monitoring and evaluation components were weak. Currently, the deputy EPI manager, who has extensive experience developing log frames in

his past position as the malaria and TB NPM for Global Fund proposals, has been assisting with this process, working one-on-one with the CSOs. There will be a series of workshops to train the CSOs on how to develop a proper monitoring framework and on reporting requirements. There will be two or three staff members invited from each CSO to maximise capacity-building within each CSO.

Reporting systems and data management

Some of the CSOs are working in newly created districts which were recently added by the government during a regional administrative redefinition process. Because of this recent redefinition, many of these newly created districts do not have data already collected, therefore the CSO will be collecting baseline data on immunisation coverage and skilled deliveries. This data will become a much-valued resource not only for the CSOs but for the MoH as well. Many of the baseline and Knowledge Attitudes and Perceptions (KAP) data collected by the CSOs under the GAVI CSO grant will supplement any missing MoH data and will also serve to verify any already existing data. The data will also help inform and update the materials developed by the CSOs working in Information, Education,



and Communication (IEC) and Behaviour Change Communication (BCC) in the field.

Three positions were created to manage and monitor the CSO initiative. In addition to the CSO coordinator, a financial and administrative person has been hired to manage the funds and provide assistance to the CSOs. These staff will be located in the UNICEF office in Islamabad. In order to streamline reporting, one of their responsibilities will be to visit CSOs and review their forms to create a set of standardised reporting forms.

Converting challenges to opportunities

One of the early implementation challenges has been the collection of baseline data. However, this can also be seen as an opportunity to build both MoH and CSO relationships as well as CSO and local government capacity. Some of the data reside at the district or provincial levels, and the CSOs will need to work in cooperation with these local level health ministry units to obtain them.

The approval of the Memorandum of Understanding in Sindh, along with others currently being drafted in other districts, may serve as a precedent for additional CSOs and districts to follow suit and formalize relationships with local level governments, further solidifying relationships. In the meantime, UNICEF will also continue to facilitate communication between the CSOs and districts to increase collaboration at the local level.

It has been reported that some CSOs have not yet received their funds due to needed work plan revisions. During the proposal development stage, the CSOs were asked to develop quarterly deliverables as part of the reporting and tracking of progress. For many of the CSOs, particularly those which are not used to developing monitoring and evaluation frameworks as part of their planning processes, their monitoring framework needed further refinement. After approval of the proposal, it has been necessary for the CSO to take its framework and develop it into a work plan with impact indicators. Until these work plans are finalised and approved so that proper monitoring implementation progress may take place, the CSOs will not receive their funding. One of the GAVI Alliance partners in country stated that there is a “strong desire by all involved to accurately document and show the impact generated by the CSOs’ work.” The CSOs have also expressed that they want to be able to demonstrate the results of their work and appreciate the monitoring and evaluation and reporting system training that is being provided by UNICEF and the GAVI Alliance. The CSOs which are still waiting for funding are actively participating as part of the consortium and will attend training workshops and meetings.

VI. Findings and lessons learned

The introduction and application process of the GAVI CSO funding support was a process that facilitated a unique opportunity for CSOs to receive a deeper understanding of GAVI and ministries work in immunisation and HSS and vice versa. It also provided a platform for the CSOs, government partners, and other stakeholders on which to interact and build stronger relationships with each other and initiate a more formalised partnership.


This new partnership was accomplished through a number of activities, including workshops for creative problem solving and resolution and the formation of a new national CSO Consortium to unify

“Generally, it is felt the selection of the CSOs is a balanced mix of those who are more established in immunisation and health systems strengthening, with those who have more experience building capacity, with others who conduct more community mobilisation or have good relationships at the local level. It is felt that these CSOs all bring skills and knowledge that each can learn from and will strengthen the bonding of this group.”
CSO Cluster Head Coordinator

the voice of civil society. One year after this initial partnership was developed, there are a number of concrete results to be seen beyond the CSO grant activities. The relationship between the CSOs and the health ministry has extended even beyond the scope of the CSO grant application process and the EPI department to include a recent MoH request for CSO support on other activities, including polio eradication campaigns and the development of a number of Training of Trainers manuals. The CSO designed interactive illustrative materials for these teams, and the overall experience was very successful. The CSO has already been asked to help with other future trainings with the MoH. In addition, the strengthened relationship between civil society and the MoH has gone beyond child health and vaccinations to include CSO participation in planning for tuberculosis and hepatitis activities with the MoH.

VII. Recommendations

As more examples of working relationships between CSOs and the public sector emerge, this may help to further build trust between these two sectors. Further partnerships would be facilitated by including regional government staff in any future events, including trainings or workshops in order that regional staff may serve as a resource in furthering MoH partnerships with CSOs.



In addition, it would be important in the future to apply a similar process to that used for the GAVI Alliance HSS consultation, whereby more field-based organisations located at the lower levels of the health system are involved from the start. It would be good to spend more time vetting this partnership and grant opportunity with the smaller and less well-established CSOs in order to ensure that the most appropriate organisations are identified to participate in the GAVI CSO grant process.

The CSOs are very interested in learning more about how the other CSOs are doing in terms of both implementation of the grant and coordination with local MoH staff in order to work together on overcoming challenges. Since the partnership modality under the GAVI CSO grant is a new one, it may make sense for funding to be made available to convene the CSOs on a more frequent basis in order to create further synergy in problem-solving.

It is suggested that the training materials, research methods, and other reference documents CSOs have developed should be shared with each other and with CSOs outside of the consortium. In addition, at some point the MoH may want to consider standardising training curriculum used across all of the CSOs both to avoid duplication of effort in curriculum development and ensure that information disseminated to health workers is harmonised and of the utmost quality.

The period of 18 months to complete activities is too short to see or measure any real changes. The immunisation cycle takes place over a five-year period, and it will be difficult to gauge the impact of the CSOs work in this period. Furthermore, part of the CSO role under the grant is to carry out advocacy initiatives, which requires a longer-term investment of time in order to see results. Many of the smaller, less experienced CSOs may have problems getting implementation off the ground and showing results, which could cause delays in disbursement of the second tranche of funding. Therefore, it would be advisable to allow more time during early implementation for planning and coordinating activities. Additionally, the project should consider allowing enough time for proper phase-out of activities so that the CSOs can devise a careful exit strategy and the work does not collapse after GAVI support ends.



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Annex II: List of interviewees

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