

20 Nov 2004

# **Alleviating System Wide Barriers to Immunization**

**Issues and Conclusions from the Second GAVI Consultation  
with Country Representatives and Global Partners**

**Oslo, Norway • 7 & 8 October 2004**

**The Global Alliance for Vaccine and Immunization (GAVI)  
Hosted and organised by Norad**

## In brief

- System-wide barriers are here defined as factors outside of the control of the immunization program that negatively affect the provision of services and reduce program performance. Typically the same barriers will also hamper the performance of other health services.
- The Norwegian Agency for Development Cooperation (Norad) has in 2004 coordinated a GAVI workplan area seeking to explore ways to address system-wide barriers to immunization. This paper summarizes the discussions held at a Consultation with countries and international partners, with key findings reported to the GAVI Board in December 2004.
- Constraints related to financial and human resources are confirmed to be the major system barriers to immunization across all countries and root causes for many other barriers, in particular at peripheral level. Better-organized districts appear to perform better and adapt to the constrained environment, underscoring the fundamental importance of leadership and management capacity.
- A number of good country practices were identified, some of which have the potential to be scaled up and used across districts/countries.
- Key elements of the approach used in the process were the use of immunization as a tracer, the classification of barriers according to performance drivers and operational level; the active search for good practices; and documentation of the process by a local research institution. There is scope to consider expanding the use of this approach to more countries.
- A desk review indicates that the performance of interagency coordination committees (ICC) varies considerably. There is agreement that one size does not fit all and that non-prescriptive and context-tailored solutions are required in different countries. The traditional ICC set-up appears to have limitations in some settings and it might be useful to distinguish between countries engaging in SWAp-like processes and countries with no such processes. Country representatives stressed the need to have a technical immunization sub-committee to ensure communication and follow-up action. Monitoring of sub-national performance needs urgent strengthening.
- Processes related to harmonization and alignment are pursued internationally under the framework of the OECD/DAC Rome Declaration (February 2003). Given its policy of multi-year and not earmarked funding, country representatives generally consider GAVI to be "light" and system-friendly. There is however scope in most countries to review coordination arrangements, anchor the GAVI process closer to broader sectoral processes, and look into the possibility of making use of common financial monitoring and reporting arrangements. Countries should themselves drive such a process, while donor partners, implementing partners and global initiatives should actively respond through alignment and effective linkages.
- Clearly a number of system wide constraints are far beyond the scope of GAVI. For some however, GAVI may have the potential to be an effective broker and pathfinder for finding ways to overcome barriers. This includes mobilizing for increased financial investment in health, including following up the financial sustainability plans at country level and anchoring these processes in sectoral planning and budgetary processes; bringing forth to the attention of global partners macroeconomic challenges related to budget ceilings and conditionalities that countries perceive are imposed onto them by the WB and the IMF; looking into possible ways to advance the human resource agenda by exploring innovative action and good practice related to increasing productivity and empowering health workers at peripheral level (e.g. by harmonizing incentives and better coordinating off-site training); and exploring possible linkages with emerging initiatives to strengthen health information systems.

The work on system barriers is proposed continued in three different tracks.

- Completing activities in the eight countries that initiated activities in 2004. These countries will implement and document efforts to address a few select barriers, ensuring they integrate and relate to overall sectoral efforts and processes. A final report summarizing progress and good practices in the eight countries will be prepared by Norad/HeSo in the fourth quarter of 2005.
- Incorporating as appropriate approaches, findings and lessons learned from the system-wide barriers work in 2004 into the proposal to be developed for GAVI Phase 2 support for immunization services. (Upon GAVI Board request, an investment case may be developed.)
- Further pursuing harmonization and alignment efforts in the spirit of the OECD/DAC Rome Declaration, specifically:
  - Reviewing harmonization and alignment issues in the upcoming revision of GAVI country guidelines;
  - Developing a set of Shared Principles (or Code of Conduct) to make maximal use of good practices identified at country level for later consideration by the GAVI Board;
  - Accelerating the work related to strengthening national coordination mechanisms, including asking countries and in-country partners to assess and report on the appropriateness of current coordination frameworks;
  - Exploring the appropriateness and usefulness of engaging through partners in joint action with the Health Metrics Network and emerging international efforts to address the human resource crisis.

# Background

System-wide barriers are here defined as factors outside of the control of the immunization program that negatively affect the provision of services and reduce program performance. Typically the same barriers will also hamper the performance of other health services.

The Norwegian Agency for Development Cooperation (Norad) has in 2004 coordinated a GAVI workplan area seeking to explore ways to address system-wide barriers to immunization. A Consultation with country representatives and international partners (listed in annex 1) was organized on 7-8 October 2004 in collaboration with WHO/EIP/SPO, the GAVI Secretariat and the Centre for Health and Social Development (HeSo), with the following objectives:

- Review system barriers and good practices identified in eight countries.
- Obtain feedback from global partners and country representatives on progress and findings.
- Identify areas for possible GAVI action or harmonization, to be brought to the attention of the GAVI Board at its meeting in Abuja 5-6 December 2004.

# Approach

The consultation was framed around the three targets in the GAVI workplan 2004-05:

- By mid-2004, agreement by major stakeholders on joint efforts to alleviate health system barriers.
- By end 2005, ICCs strengthened, with stronger links to NGOs and higher level coordination mechanisms.
- By end 2005, efforts in 10 high- and 10 low-performing countries undertaken, lessons learned, documented and best practices shared.

Possible GAVI action was discussed in light of "GAVI added value":

- Coordination and consensus-building
- Funding support to countries from the Vaccine Fund
- Innovation
- Advocacy and communications

The consultation used as a starting point findings and experiences from work undertaken in eight countries in May-September 2004. In addition, findings from two desk reviews (one on global harmonization and efforts to address system barriers, the other on national coordination mechanisms for immunization) were presented and elements brought into the general discussion<sup>1</sup>.

Acknowledging that system barriers primarily need to be addressed through overall health sector development efforts, the Consultation focused on identifying:

- Areas where immunization has a particular stake and a comparative (pathfinder) advantage, and which could be used as entry points for making systems more responsive to the needs of immunization programs. Addressing these areas could help bridge program-specific actions and broader health sector development efforts.
- Issues to be brought back into GAVI processes, such as advocacy, harmonization and alignment efforts<sup>2</sup>, and further development of country support approaches.

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<sup>1</sup> Background documents, country cases and presentations are available on the GAVI website [www.vaccinealliance.org](http://www.vaccinealliance.org)

<sup>2</sup> The GAVI Secretariat updated on activities related to GAVI Phase 2 including the establishment by the UK of an International Financing Facility for Immunization (IFFIm).

# Country findings

## Process

The initial intention to engage “10 high- and 10 low-performing countries” was in consultation with WHO adjusted due to the “initiative overload” currently experienced at country level. An official request soliciting country interest was forwarded in March 2003 to ministries of health in 11 countries. Eight of these countries (the Gambia, Ghana, Guyana, Rwanda, Sierra Leone, Uganda, Vietnam, Zambia) have participated in the process<sup>3</sup>. Due the selection bias, most countries are high-performers with high national DPT3/Penta3 coverage.

Except for Sierra Leone, countries met in Oslo on 7 October to discuss their reports and preliminary plans. Major findings and issues were presented in the Consultation on 8 October.

## Barriers

Constraints related to financial and human resources are confirmed to be the major system barriers to immunization across all countries and root causes for many other barriers, in particular at **peripheral level**. Not surprisingly, better-organised districts appear to perform better and adapt to the constrained environment, underscoring the fundamental importance of leadership and management capacity.

- Financial constraints are related both to the **insufficient level of resources** going to health care, **management inefficiencies** in particular slow and irregular disbursement of funds to peripheral level, and insufficient allocation (to immunization/PHC out of total) and limited flexibility in the use of resources at peripheral level. Countries that have introduced new vaccines are also facing a significant funding gap. Macro-economic constraints related to public sector conditionalities set by the International Monetary Fund (IMF) and budget ceilings imposed by ministries of finance are perceived to be significant constraints for the organisation and performance of public services.
- Countries handle the **coordination of development partners** in different ways. While the majority of the eight participating countries report that coordination of immunization efforts is reasonably effective, this does not appear to be generally the case (more on this in the next section). While GAVI is considered to be relatively “light” and flexible, global health initiatives in general are considered to be resource-intensive and cumbersome.
- Countries report that a complex and inter-linked web of **human resources constraints** significantly affect health worker performance and the delivery of services. Key issues are weak incentive and support systems for public sector staff, including low levels of pay and formal allowances, limited career prospects and difficult working conditions that impede the execution of duties (e.g. lack of mobility and transport, allowances, drugs and equipment). Under-investment over a number of years and an unwillingness to seriously address human resources issues have failed to establish effective systems for workforce planning, production and management, resulting in shortages, maldistribution, and inadequate skill mix. The human resource crisis has been exacerbated by the international migration of health professionals and the AIDS epidemic, which has reduced the size of the workforce, increased workload and affected work morale.
- Of particular importance to immunization, timely availability of staff, transport and funds at sub-national (district) and facility level remains a major barrier in all countries and impacts the organization of **outreach activities**. Despite their critical importance for coverage (accounting for more than half of all immunization contacts in a majority of countries) and their potential to provide an additional array of services, outreach strategies appear to be ill-defined and their implementation left up to individual health workers. This includes the definition of the contents in the “outreach package”, the place of outreach activities within the overall service delivery strategies (e.g. scheduling with regard to

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<sup>3</sup> Cambodia, Lao PDR and Malawi have indicated their interest to engage in such work at a later time.

- frequency and seasonal variations, the relation to other activities such as child health days), support systems (logistics and transport, allowances), monitoring and financing.
- While **demand-related issues and community mobilization** were not raised by peripheral health workers as major barriers (they were at central level!), this area remains a challenge for immunization programs and requires more attention in particular within the context of outreach activities and reduction of drop-out rates. Increasing the general availability of immunization-related information at district level starting with coverage rates is needed to increase public awareness and demand as well as political commitment.
  - Although the long-term goal should be to get more and better-qualified health workers at district and service delivery level, country studies show that the **effective use of existing health workers** should not be overlooked. Numerous workshops and training activities, usually program-specific and donor-financed, take staff away from their daily functions, especially at district level. This affects supervision, monitoring and management activities and is allowed to go on because allowances constitute important sources of income for under-paid staff.
  - Although significant weaknesses in health and information systems and data quality were observed in all countries, the main problem is related to the **low use of available data** at the appropriate level, as a starting point for improved planning and monitoring. While this is commonly the case at district and service delivery levels, it is most striking at central level, where key information such as district immunization coverage and vaccine stock levels do not appear to be tracked and used as a way to direct efforts and resources. Uncertainty about the denominator remains a problem in several countries.
  - **Post-conflict situations** present with special barriers. In addition to the overall challenge of rebuilding the infrastructure and re-establish management systems, the transition from donor-management with dedicated resources to Government-owned appears to be particularly challenging. Weak health information systems, shortage of skilled human resources, and weak financial management procedures appear to be of particular importance.
  - Interestingly, while it was acknowledged that structural and system changes had occurred as part of health sector reforms, countries reported very few negative effects of the reforms themselves when assessing barriers. Weak design and execution of certain reform elements appear to be more of a problem, including equity concerns and engagement of civil society. Specifically, **private-for-profit health providers** are a growing sector and are not well utilized especially in urban and peri-urban areas. Poor interest of local politicians in decentralized settings was reported in one country, while this had been addressed in another country by allocating conditional primary health care grants to districts.

## Good practices

A number of good practices were identified, some of which have the potential to be scaled up and used across districts/countries. The following good practices were noted concerning the major barriers identified above.

Addressing manpower shortage and making more effective use of the existing workforce:

- Because of the shortage of trained staff, lower-level cadres (e.g. auxiliary staff) are increasingly being used for service provision including vaccination. In Uganda, staff have been trained and upgraded to a new cadre of Assistant Nurses. Though this raises several issues such as staff remuneration and scopes of practice, such approaches could help alleviate staff shortage at peripheral levels in the shorter-term and increase the probability that staff will remain in place. The Ghana Health Services has also developed strategies to reduce manpower shortage, including increased intake into training schools, establishing systems to stop increased attrition and retain staff; car loan scheme and housing loans; training opportunities; and a deprived area incentive scheme.
- The recalling of retired nurses (in Zambia) or keeping on nurses after retirement (in Guyana) are important measures to retain qualified staff. A root problem in many low-income countries appears to be the low retirement age for public servants.
- Pre-service training curricula have been revised in several countries and made problem-based to better prepare health workers for work in health facilities.

- Uganda (as well as Sierra Leone before the conflict) coordinates training workshops at central level and issues a calendar of events. This helps to coordinate programs and better plan time use, to reduce staff absenteeism at district and health facility level.
- Allowances are key in systems with low wages. In Uganda, donors have for some years used standardized rates for incentive payment in donor-supported programs aligned with government rates, thereby reducing competition between different programs.
- In Zambia there is a program for rural retention offering rural allowances and car loans for doctors. Another way of increasing retention is by making anti-retroviral treatment (ART) freely available for health staff in countries with a high HIV positive prevalence.
- Efforts to involve the private for profit sector in immunization have been initiated in Ghana, where private midwives have been trained in three regions to provide immunization.

Translating political commitment (seen in all eight countries) into action:

- Coordination of stakeholders is well managed in these high-performing countries, either through SWAp arrangements with basket funding (Zambia, Ghana and Uganda) or through well-functioning interagency coordination committees (Guyana, Vietnam). In Vietnam, some of the ICC technical members operate as a working group and meet frequently to plan and coordinate activities. In Sierra Leone, the Hon. Minister of Health has taken the initiative to pool priority programs (incl. malaria and immunization) into one Action group for Maternal and Child Survival to promote program collaboration and increase coordination effectiveness.
- Low-performing districts in Ghana are supported to conduct micro-planning to improve supervision and outreach services, and hold monitoring and review meetings funded through the district budget and external funding. Targeted support to lower-performing districts is provided in several countries (Ghana, Uganda).

Making better use of health management information:

- In Uganda a league table with 18 indicators is published in newspapers to show high- and lower-performing districts. In addition to make district leaders more accountable for performance, the league table is used to direct technical assistance to weaker districts. Applying the WHO Reach Every District (RED) approach to analyze district performance, remarkable improvement in immunization coverage has been seen in some districts in the span of one year.
- Expanding private sector engagement, in particular NGOs, has been successful in several countries by exchanging vaccines for monthly activity reports. This helps to feed private sector activities into the HMIS.

Based on these country findings, annex 2 describes a comprehensive set of inter-linked practices and conditions that need to be in place at peripheral level to assure good performance.

## Feedback on the methodology

A rapid barrier assessment methodology developed by the Centre for Health and Social Development (HeSo) with inputs from WHO/EIP/SPO, the Institute for Health Sector Development (IHSD) and the GAVI Secretariat formed the basis for in-country activities<sup>4</sup>.

Key elements include:

- The application of a semi-structured assessment tool to collect information using immunization as a tracer, shaped around a set of statements presumed to be representative of system barriers typically encountered at country level.

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<sup>4</sup> See "Country Assessment and Planning Guide "Efforts to address system wide barriers to immunization in selected countries, Basic elements of approach, process of work and tools", HeSo, Draft May 2004.

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- The classification of barriers in “buckets” according to performance drivers<sup>5</sup> and the operational level at which they operate.
- The active search for good practices.
- The development of a simple plan to address a few select barriers.
- Active participation in and documentation of the process by a local research institution.

Local research institutions provided the following feedback on the process and the tools.

#### Strengths

- Covers key areas of system wide concerns of importance for immunization program performance
- Sensitive and specific in relation to health system
- Captures good practices
- Potential to improve the management of immunization programs, with potential spin-over effects on other programs
- Enhances informed decision-making at different levels
- Tool is adaptable to other programs

#### Shortcomings

- Issues related to community concerns, mobilization and demand not sufficiently addressed
- Not suitable for self-administration at lower levels
- Language requires further simplification
- Some study teams propose reformulating statements into questions
- No consensus on the value/usefulness of the scoring system (1,2,3)

There is scope to adjust the tools and use the approach in more countries, either as a required step for future GAVI-related support or as a component in regular EPI Reviews.

It was noted that findings were usually known in countries that are in advanced stages of health sector development and where sectoral reviews and appraisals have been organized as part of the sectoral planning process. In situations where information is readily available, no specific system barrier analysis is required. Such work is likely to be of interest also to national academic institutions, such as in their training programmes and in implementation research.

## Developing effective national coordination mechanisms for immunization

Effective coordination at country level is critical for making systems more responsive, transparent and accountable. Countries increasingly report that the emergence of global initiatives and the multitude of development partners constitute a system barrier in itself if left unchecked. Transaction costs are high and national prioritization and decision-making processes may be skewed.

The commonest coordinating body for immunization at country level is the interagency coordinating committee (ICC) with a history associated with polio eradication. A functioning ICC - or an equivalent mechanism - is a principal GAVI condition for Vaccine Fund support. Specifically, it is required to endorse country proposals and progress reports prior to submission to GAVI.

As noted by GAVI's independent review committee, ICC performance varies considerably. An informal review of more than a hundred GAVI applications in 2001-03 indicated that less than 10% of ICCs routinely discuss routine immunization. Only 3 out of 45 ICCs reported in 2003 to have discussed GAVI/VF financial support (ISS). Some ICCs have adopted and implemented new policies with significant financial implications (such as introducing a costly new vaccine) with little involvement of sectoral planning and decision-making bodies.

The document review indicates that sub-optimal ICC performance may be due to several reasons, including:

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<sup>5</sup> Building on the work done by McKinsey & Co. for the GAVI Board in 2003.



- Uneven stakeholder representation, with development partners more prone to project-funding far more engaged in the ICC than those more likely to support sector-wide approaches (SWAp). Civil society and other parts of the public sector (e.g. the finance ministry) are usually not well represented.
- An ambiguous ICC mandate and terms of reference, with a scope that includes both technical deliberations and high-level decision-making.
- Unclear role and accountability of ICC members, for example with regard to signing-off the GAVI country proposal and monitoring report.
- Differing partner objectives leading to fragmentation and a lack of comprehensive approach (e.g. focusing only on particular aspects of the program).
- Insufficient capacity in the ministry to lead, manage, and follow-up ICC processes.
- Institutional or individual resistance, since improved coordination and transparency may lead to changes in established practices and procedures and loss of power.
- Difficulty in effectively linking up with authorities and service providers at sub-national level, especially in decentralized (devolved) settings.

Several other processes and frameworks may impact directly or indirectly on the immunization program:

- Poverty Reduction Strategy (PRS) processes, which are being implemented in more than 70 countries and link with debt relief initiatives (e.g. HIPC) and increasingly with the MDGs. 19 out of 20 final PRS Papers in Africa include immunization as an indicator of progress.
- Multi-sectoral public planning and budgeting frameworks, such as medium term expenditure frameworks (MTEF), used to allocate resources to each sector. This could be further strengthened through medium term human resource frameworks.
- Sectoral Program Based Approaches (PBAs), including SWAp-like initiatives and baskets, which have emerged in many countries as a response to “fragmented, donor-driven projects”. There is a general trend among donors toward moving from project to program based approaches.
- UN reform processes (e.g. UNDAF/CCA) intended to simplify and harmonize procedures among UN agencies and introduce common planning and monitoring frameworks.

Countries reportedly address the issue of donor coordination for immunization in a variety of ways. Zambia has dissolved its immunization ICC and intends to integrate it into its health sector development institutional framework. The Tanzania and Gambian MOHs report that their Immunization ICC performs well and is still a useful structure thanks to strong Government leadership. Sierra Leone has reported that the Hon. Minister of Health intends to consolidate existing coordination mechanisms and establish an Action Group for Maternal and Child Survival to oversee Government and partner efforts in key health priorities, including malaria and immunization.

There was general agreement at the Consultation that:

- **One size does not fit all. Non-prescriptive and context-tailored solutions are required in different countries.**
- There is much scope for performance improvement of coordinating mechanisms in a majority of Vaccine Fund eligible countries, and that experiences should be applied across countries.
- **Focus should be on functions rather than on the structural set-up** of the coordination body. The monitoring function needs urgent strengthening focusing on a small set of indicators, for example district coverage, vaccine stock levels, surveillance and financial expenditure.
- The traditional ICC set-up has limitations in some settings, in particular when functional sectoral frameworks are in place. **Placing accountability at the highest level with most appropriate representation, budget leverage and decision-making authority is key.**
- The usefulness of bringing together in a ICC like mechanism health system functions and services that target the same groups and in a particular way benefit from joint efforts should be seriously considered, such as for instance in the case of immunisation and malaria
- **It might be useful to distinguish between countries engaging in SWAp-like processes and countries with no such processes.** In countries with a SWAp,

- immunization partners including GAVI could consider aligning with and using the local planning, monitoring and financial frameworks.
- Regardless of the structural set-up, country representatives stressed the need to have a **technical immunization sub-committee** (or working group) led by the MOH and composed of the key technical partners that meet regularly, ensure action follow-up and support the work of the decision-making body. In countries with a SWAp, this could be taken on by a more narrowly defined ICC, which could then make the “immunization voice” heard among SWAp partners.

Of interest to GAVI, the Global Fund to fight AIDS, TB and Malaria (GFATM) is in the process of clarifying the modalities of their Country Coordination Mechanism (CCM) and is in several countries exploring the use of SWAps and budget support frameworks.

## Global efforts to alleviate system barriers

A desk review has been undertaken to map initiatives targeting system barriers organized by international institutions and global initiatives and identify entry points and areas for possible GAVI “added value” engagement or follow-up.

Two main types of efforts have been identified:

- Efforts to improve the coordination and merging of processes, institutions and systems among aid agencies/stakeholders (i.e. harmonization) and improve development assistance coherence with and integration in systems and institutions of the receiving country (i.e. alignment);
- Efforts targeting specific program areas, such as information systems and human resources for health.

## Harmonization & alignment

Processes related to harmonization and alignment are pursued internationally under the framework of the OECD/DAC Rome Declaration (February 2003). Key elements of the Rome commitments are to:

- Ensure that harmonization efforts are adapted to the country context, and that donor assistance is aligned with the development recipient's priorities.
- Expand country-led efforts to streamline donor procedures and practices.
- Review and identify ways to adapt institutions' and countries' policies, procedures, and practices to facilitate harmonization.
- Implement the good practices, principles and standards formulated by the development community as the foundation for harmonization.

The OECD/DAC Working Party on Aid Effectiveness and Donor Practices is tasked to facilitate and support the implementation of the Rome commitments. The second high level forum on Harmonization and Alignment for Aid Effectiveness (HLF-2) will take place in Paris in February/March 2005 and is seen as an important opportunity to summarise experiences to date.

In the area of HIV/AIDS, special efforts have been made to harmonise among the multiple actors in the country level response. While one has recognized that the long term aim is to harmonize all donor procedures and practices according to the Rome agenda, donors and countries have agreed to a first step harmonisation applicable to AIDS. This approach is labelled “The Three Ones”, calling for one common action framework for the AIDS response, one authority as a custodian and convenor for this multi-stakeholder action framework and one common M&E framework.

Regardless of the development of these approaches, there is a clear harmonisation and alignment agenda where the main challenge is to cover mainstream health sector development as part of a broader MDG effort, and parallel to this to explore ways by which global initiatives can fit in.

- Given its policy of multi-year not earmarked funding, country representatives generally consider GAVI to be “light” and system-friendly. There is however scope in most countries to review coordination arrangements, anchor the GAVI process closer to broader sectoral processes, and look into the possibility of making use of financial monitoring and reporting arrangements and financial management arrangements. Countries should themselves drive such a process, while donor partners, implementing partners and global initiatives should actively respond through alignment and effective linkages.

## Alignment with other efforts targeting specific barriers

A multitude of development partners and global initiatives are directly or indirectly engaged in addressing system barriers. This includes international financing institutions, UN agencies, bilateral partners, international NGOs and initiatives such as the GFATM, Roll-Back Malaria, Stop TB and the 3by5.

Clearly a number of system wide constraints are far beyond the scope of GAVI. For some however, particularly those closely associated with immunization, GAVI may have the potential to be an effective broker and pathfinder for finding ways to overcome barriers. This underlines the value in mutual recognition and well coordinated approaches.

GAVI may in this serve both as an advocate and facilitate discussions with other agencies and initiatives, in addition to providing support for country efforts through the immunization window..

**Mobilising support for increased financial investment in health** is now high on the global development agenda, largely through the work of the Commission on Macro-economics and Health (CMH) and the imperatives of the HIV/AIDS pandemic. For global initiatives such as GAVI/VF and the GFATM, this is a constituting task. The need for major new investment is also a central message of the UN Millennium Project Report.

- For GAVI, following up the financial sustainability plans at country level constitute a framework for action and a major contribution from immunization partners. Anchoring these processes in sectoral planning and budgetary processes will be key.
- Macroeconomic challenges related to budget ceilings and conditionalities linked to HIPC processes remain important constraints for countries, and should be addressed by partners especially the World Bank in collaboration with IMF.

The importance of **human resources for health (HRH)** is emerging as a major factor for achieving the MDGs. In light of the crisis brought about by AIDS, general under-investment in the health sector together with poor and demotivating working conditions and health worker migration exceptional action may be indicated in the health sector. The High Level Forum in Abuja in December 2004 will seek agreement among key partners that HRH represents an emergency and top priority agenda, and call for coordinated and comprehensive follow-up action. This work needs to be country owned and context-specific, building on some strategies that are already working and scaling up strategies that can be made to work.

- GAVI may contribute to this human resource agenda by exploring innovative action and good practice related to increasing and empowering health workers at peripheral level (district and health facilities). In particular, the immunization field is well placed to explore how the value and productivity of the Health Worker can be enhanced through financial and non-financial motivation systems in ways that can be sustained. This includes establishing supervisory supportive and learning opportunities and increasing mobility. Targeting the most deprived and lower-performing areas should be considered.
- The area of human resources lends itself to harmonization and alignment and can help drive improvements in aid effectiveness and health system performance. In particular, the harmonization of incentives across immunization and non-immunization activities, the coordination of off-site training and workshops, and a shift towards establishing supportive on-the-job capacity development systems are issues under the influence of external partners involved in immunization.

With regard to **health information systems**, the Health Metrics Network (HMN) established in 2004 will likely provide areas for potential pathfinder action or harmonization

for immunization, in which immunization experiences in particular at most peripheral level could be used. At country level, in line with the need to strengthen monitoring of district performance and assistance to lower-performing areas, immunization partners could ensure that immunization gets included and is used in the in-country task forces proposed to be established. Experiences and findings stemming from the GAVI Data Quality Audits (DQA) could also be brought into this process, as well as approaches related to diagnosis and tracking of drop-out rates.

## New ideas for country support from the Vaccine Fund

GAVI has solicited ideas concerning new ways in its next phase (2006-2015) of providing country support. The most promising ideas may be developed into investment cases for consideration by the GAVI Board in the first half of 2005. There may be opportunities to link this up with the establishment in early 2005 of the International Financing Facility for Immunization (IFFIm).

Based on the experiences in 2004, participants at the Consultation discussed possible options for Vaccine Fund investment into addressing system barriers to immunization. The following concept was advanced<sup>6</sup>.

- **Investment for system strengthening could be directed towards overcoming system barriers of relevance to immunization (but not be limited to immunization) in low-performing districts.** Sub-national (district) and service delivery levels are key to improving basic service delivery but are currently neglected.
- A key requirement could be the preparation and submission of a **credible action proposal**, focusing on doable short-term and longer-term solutions, and with priority to barriers critical for increasing access and coverage in the periphery.
  - A participatory barrier analysis could be required as a step in developing this action proposal. A modified version of the rapid assessment tool, or other equivalent process/method if already applied in-country, could be used and applied together with the Reach Every District (RED) approach.
  - The action proposal would need to be based on and explicitly feed into existing health plans at sub-national (district) level.
  - Three areas critical to expand and sustain services could be given special consideration: (1) complementarity of various funding sources, in particular Government budget but also other external sources, and effectiveness/timeliness of disbursement; (2) expanded involvement of the private sector, including NGOs, in planning and delivering services; (3) expanded interface and mobilization of communities.
  - Operational research should be established at local level to expand the body of evidence about what works and what does not.
  - System strengthening support should follow regular country support processes in GAVI's Phase 2 (application, proposal review, disbursement, monitoring and reporting).
- Principles for Investment from GAVI in phase II could include:
  - **Flexibility** (i.e. not earmarked) to allow for innovative approaches, increase aid effectiveness and reduce transaction costs.
  - Provided in principle for a period of five years to increase **predictability**.
  - **Subject to performance** assessed on the basis of performance indicators to assure accountability, primarily immunization coverage (e.g. DTP3) but also one or more additional indicators indicative of broader health system performance.
  - **Decided on a capitation basis** (e.g. based on the number of unimmunized children) to retain a simple and common approach across countries and districts. One should though recognize that such an approach may not meet all needs.

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<sup>6</sup> Details were further elaborated in discussions with the GAVI Working Group subsequent to the Consultation.

- The rationale for applying a performance-based funding approach for strengthening of district health services was put as follows:
  - It would address the two major barriers of predictable financing and human resource productivity at sub-national level.
  - It could help advance the state of knowledge about incentive-based approaches to improving health worker productivity.
  - It would advance equity consideration by focusing on district performance.
  - It would be a natural expansion of GAVI's ISS performance-based approach.

## Way forward

Norad will report on progress and findings to the GAVI Board at its Abuja meeting 4-5 December 2005. This report will serve as a background document.

The work on system barriers is proposed continued along three different tracks.

- **Completing activities in the eight countries that initiated activities in 2004.** These countries will implement and document efforts to address a few select barriers, ensuring they integrate and relate to overall sectoral efforts and processes. A final report summarizing progress and good practices in the eight countries will be prepared by Norad/HeSo in the fourth quarter of 2005.
- **Incorporating as appropriate approaches, findings and lessons learned from the system-wide barriers work in 2004 into the proposal to be developed for GAVI Phase 2 support for immunization services.** (Upon GAVI Board request, an investment case may be developed.)
- **Further pursuing harmonization and alignment efforts in the spirit of the OECD/DAC Rome Declaration, specifically:**
  - Reviewing harmonization and alignment issues in the upcoming revision of GAVI country guidelines;
  - Developing a set of Shared Principles (or Code of Conduct) to make maximal use of good practices identified at country level for later consideration by the GAVI Board;
  - Accelerating the work related to strengthening national coordination mechanisms, including asking countries and in-country partners to assess and report on the appropriateness of current coordination frameworks;
  - Exploring the appropriateness and usefulness of engaging through partners in joint action with the Health Metrics Network and emerging international efforts to address the human resource crisis.

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## Annex 2

Some issues from the country studies on health system barriers with focus on service delivery (draft 3)

The GAVI country studies on health system barriers and good practices organized in April – September 2004 in eight countries (The Gambia, Ghana, Guyana, Rwanda, Sierra Leone, Uganda, Vietnam, Zambia) have clearly shown that shortages in human resources are major barriers to immunisation. The problem is especially felt in facilities where Primary Health Care (PHC) services are provided. The long-term goal is clearly to get more and better-qualified health workers at this level.

In the meantime, the effective and efficient use of health workers in PHC is a major issue. Preventing loss of these workers from the public sector is another concern.

Using country findings and experiences, we have identified a set of conditions that need to be in place to address the barriers. These conditions are usually inter-linked, and if one condition is not met, it may strongly affect the entire system. The state of PHC development will determine which of the conditions mentioned below are most applicable to the local setting.

Potential entry points for GAVI/partner action are marked with (\*).

### Finances

*Predictable funding* to be available at facility and district level at all times to deal with issues like salaries, allowances and transport. If there are frequent delays in disbursement from the appropriate level and this is not easily resolved, a revolving back up fund or 'fast track funding' could be contemplated for the sub-national level while improving on disbursement through the main channel<sup>7</sup>\*. Timely finances are the most important issue, which will affect all the other conditions stated below.

### Mobility

*Mobility* is crucial for outreach and supplies within a defined catchment area. Hard to reach areas will require special attention. A transport plan with focus on outreach will need to be costed. Clear regulation and guidelines need to be spelt out, especially what to do when transport breaks down or is insufficient, e.g. permission for use of local transport. Preventive maintenance and funds for repairs are other issue. Funds will need to be available for such actions all the time\*.

### Skills

*Supportive supervision* is important for improving quality of service. To the extent possible, time should be spent by a supervisor from district or sub-district level *in the units* for such work. Some of the supportive supervision could replace in-service training away from station<sup>8</sup>. The use of health management system for planning should be an important task for supportive supervision.

For this to happen, health workers at the appropriate level (usually district or sub-district) need to have the means for supportive supervision, i.e. appropriate skill mix, transport and if applicable allowances for work out of station

The multitude of uncoordinated training sessions away from station strongly affects service delivery in many countries. A training coordinator may work closely with all programmes and compile all trainings and workshops into one calendar of prioritised events. Integrated training sessions should be endeavoured.

*Upgrading of skills*, especially of auxiliary staff and other staff with minimum training, who lives in the community, could increase the number of skills who meet the standards required

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<sup>7</sup> There was no agreement on the use of alternative funding channels during the consultation.

<sup>8</sup> Development partners often pay for such training sessions. Funding could be re-allocated to in-service training.



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for immunisation services. With a modest increase in wages, many of these persons can provide reliable immunisation service long time\*.

#### Incentives

All the issues mentioned above could act as *incentives* for work if they are resolved, and add prestige to the health workers. Monetary incentives should also be considered for delivery of outreach services, but partners need to agree on the level of incentives to prevent programme competition and distortion\*.

#### Public/private partnership

When appropriate, *Private for Profit and Private not for Profit providers* and religious health associations should be involved in immunisation and other aspects of public health work\*.

#### Community participation

*Active participation of the community* is important for getting the children to the clinics/outreach. The interface between the formal health system and community action for health i.e. health facility committees and community health workers, is often the best strategic focus for such action. Communicating with influential politicians and religious leaders would supplement such an approach. Issues like potential vaccination side effects should also be addressed during the communication, thus preventing rumours of groundless dangerous side effects being spread. Drop out rate of more than 10% of DPT/Pentavalent should initiate an inquiry in the community as for possible causes.

#### Integration of services

Among other factors, which may improve efficiency, is *integration of services* in outreach. *Pre-service training* reflecting the challenges in the field will often need to be strengthened.

#### Innovations

Innovatory approaches to improve outreach coverage and equity, especially in relation to reaching the poorest, should be sought, documented and scaled up. Performance based funding with rewards for good practice at district and facility level, may be one way of improving coverage. \*

#### Post-conflict situation

Improving immunisation coverage in post-conflict areas will need to be dealt with separately. Linked to this issue is mapping of people who are not registered locally e.g. refugees.