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Update on joint HSS platform with GFATM and World Bank

Background

There is increased recognition of the importance of Health Systems Strengthening (HSS) as a necessary element for achieving better health outcomes and health related Millennium Development Goals. This has led to new-found political, financial and technical support of HSS. The drive to strengthen health systems is coupled with efforts to improve aid effectiveness, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action as well as principles outlined in the International Health partnership (IHP+). These aim to improve the efficiency and accountability for aid and to reduce transaction costs for countries through better harmonisation and alignment.

In March 2009, GAVI Alliance CEO Julian Lob-Levyt and Global Fund to Fight AIDS, Tuberculosis and Malaria Executive Director Michel Kazatchkine wrote to Prime Minister Gordon Brown and World Bank President, Mr. Robert Zoellick, co-chairs of the *High Level Taskforce on Innovative International Financing for Health Systems (HLTF)*. The letter outlined the intent to strengthen coordination with the World Bank and others to make the health architecture more effective globally and at the country level.

An update was provided to the HLTF, which delivered its final report in Paris at the end of May 2009¹. More formation about possible sources of support to help countries access essential support to address health systems bottlenecks will be provided at the 23 September meeting at the UN General Assembly in New York.

Coordination is critical to achieve the health Millennium Development Goals (MDGs) by 2015, particularly in the area of maternal and child health to which both organisations and the World Bank contribute significantly: funding platforms to deliver immunisation services, prevention of mother to child transmission of HIV, sexual and reproductive health, and protection of pregnant women and small children from malaria.

In the 72 poorest countries supported in common, GAVI, Global Fund and the World Bank are the largest external investors of health systems:

- From 2006 to 2008, Global Fund commitments for health systems were almost \$1 billion
- From 2001 to 2008 GAVI Alliance support for systems was \$946 million²
- Between 2004 and 2008 the World Bank's IBRD/IDA thematic commitment to 'health systems performance' was around \$1.8 billion.

The proposal

¹ See http://www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf

² This includes HSS support, Immunisation Services Support (ISS) and CSO support

FOR INFORMATION

Overall purpose: To improve health outcomes through strengthening countries' health systems to deliver health services equitably and sustainably (focusing on all health MDGs), and to use resources more effectively and efficiently.

There are already good examples of joint work between the three funding agencies, and with others. But a step change is needed. The work around the joint HSS platform has focused on what processes and procedures might need to be adapted and harmonised to take forward a joint programming and funding platform between the three agencies. These include:

- i) *Joint assessment of national health plans* (For the purposes of the joint programming and funding platform, a National Health Plan comprises four elements: National Health Plan and Budget, Programme Specific Strategy, Annual rolling implementation plan and a M&E framework) on which to base an initial funding decision
- ii) *Use of a common monitoring framework* emphasising performance based funding to monitor implementation and reward achievement of results; and
- iii) *Joint funding* platform arrangements between the three funding entities

The World Bank has different processes and can take certain decisions, if consistent with the Health, Nutrition and Population Strategy, at management level. Whilst the paper focuses on GAVI/GFATM/WB, other agencies – notably WHO, UNICEF, UNFPA and other H8 agencies (UNAIDS, Bill and Melinda Gates Foundation) – have key roles to play. Bilaterals are significant external funders in many countries, but most bilateral funding is channeled directly at country level. The scope of the proposal is necessarily limited to the three funding entities.

GAVI, GFATM and WB have increased resources for health and AIDS, which is very welcome. But it has come at some cost. The primary intent of the joint HSS programming and funding platform is to refocus the transaction costs incurred by country governments to funders, and to ensure that programming and funding is aligned with national health planning and budget priorities and cycles.

Planning, prioritising and budgeting cycles: Currently the GAVI and GFATM application and HSS disbursement processes do not necessarily align with country planning, budget and review cycles. The WB process is more aligned. Often the investments may not be considered in the broader context of overall health sector planning in resource constrained environments, leading to misalignments and skewing of health budgets. The aim of this initiative is to bring joint HSS support in line with countries' own cycles, priorities and review progress at a time that fits in with country processes.

Defining what would be considered for funding: There needs to be common understanding of what is meant by a National Health Plan and strategy, and a common understanding of what is subsequently being assessed and appraised for funding.

Links with Sector Wide Approaches (SWAs): *There is much to be learnt from SWAs. A successful SWAp has the following core elements:*

FOR INFORMATION

1. A coherent **strategic framework** showing health needs, details of on-going programmes and any gaps between the two;
2. An agreed **financing framework** such as medium term expenditure framework (MTEF). This shows the cost of existing programmes and the cost of planned new programmes needed to meet identified unmet priority needs;
3. An **MoU** or agreement setting out, among other things, the responsibilities of each party (i.e. Govt and partners);
4. A shared analysis or **diagnosis of fiduciary risk** in the health sector specifically but linked to country-wide studies (often in practice different partners require their own HQ fiduciary risk analysis methodologies to be used);
5. A shared and common **sector capacity** building plan;
6. Agreed **common M&E arrangements**, normally with an annual review

Principles: A joint GAVI – GFATM- WB funding and programme HSS platform would take account of the following principles, which have been discussed by the PPC:

- **Differentiated approach:** There is no ‘one size fits’ all solution. Processes must acknowledge variation between countries in terms of needs and requirements. Fragile states³, with weaker governance structures and capacities might need different mechanisms.
- **Use IHP+ principles:** decreasing process burden on countries, and using **one unified national plan and budget**. Support country centred nationally owned health plans, programme (disease) specific strategies and rolling annual plans. These would also include performance based M+E frameworks and be aligned with national budget cycles.
- **Common frameworks for assessment, approval, implementation and monitoring** will be used. This will result in shared analysis, common frameworks for approval⁴, risk assessments including fiduciary risk etc. which allows monitoring of programme specific investments.
- **Focus on country results and value for money:** Demonstrate value for money, and reward achievement of results.
- **‘Readiness’ for funding:** Support countries with agreed criteria, starting with 4-5 countries in 2010, and then over time, possibly up to the 49 Low Income Countries⁵. Initial selection could include countries which have undergone a joint assessment process. These countries should not only be ‘mature’ countries, but also include at least one fragile state in 2010.
- **Ensure strategic focus is maintained:** Each of the agencies has a core mandate and its own added value. An overview of strategic advantages was provided in the Geneva August meeting. GAVI’s is clearly in the area of immunisation, but immunisation outcomes are reliant on HSS. A balance must be struck to ensure support for HSS does not displace existing support for other immunisation related activities.
- **Auditing and accountability:** Funds should flow through auditable and accountable fiduciary mechanisms.

³ <http://www.oecd.org/dataoecd/14/14/43293581.pdf>

⁴ In the case of the World Bank this refers to the project preparation process

⁵ GFATM (140 eligible), GAVI 72 eligible and WB (78 IDA eligible) work in many more countries

FOR INFORMATION

- **Technical support:** The need for high quality, impartial, technical support is acknowledged, but this needs to be demand driven, harmonised and transparently provided.

The potential: *Political, financial and increased effectiveness, in line with IHP+ principles:* A joint platform for funding and programming HSS would significantly decrease transaction costs for countries. This is in line with the Paris Declaration on Aid Effectiveness, Accra Agenda for Action and IHP+ principles. It will improve coordination, and will likely leverage additional resources. Some key donors have already advised of their intention to fund a joint platform, should it be established.

The investment is needed to overcome health systems barriers to deliver cost effective health packages and new technologies necessary to reach the MDGs. The scale of investment needed to deliver such vaccines against rotavirus and pneumococcal disease, malaria (when available) or Human Papilloma Virus (HPV) is significant; furthermore, other components of the health sector need to be considered (such as reproductive and maternal health). A joint platform is consistent with the objectives outlined in the 2009 World Health Assembly resolution on primary health care and health systems strengthening⁶.

In summary, a proposed joint HSS programming and funding platform has the potential to:

- Leverage **new resources** for health outcomes, including introduction of new technologies such as new vaccines (focused on, but not limited to MDGs 4, 5 and 6) thereby improving health outcomes;
- Increase **sustainability** of the GAVI approach by ensuring that delivery of GAVI vaccines is a key deliverable of any costed health sector strategy;
- Increase **efficiency** in aid flows - jointly assessing national health plans will reduce the chances of duplication and increase harmonisation of overall support for health;
- Reduce **fragmentation** in health systems support thereby reducing **transaction costs** for countries and partners (by obviating the need for donor specific proposals and annual progress reports);
- Reduce **fiduciary risk**, with more transparent oversight by in-country partners. This is an important issue for GAVI intrinsically, and in light of the Transparency and Accountability Policy (TAP), and
- Increase **inter-secretariat efficiency** and effectiveness by encouraging joint working between GAVI and GFATM, linking with the World Bank processes. It could join GAVI Independent Review Committee (IRC) / GFATM Technical Review Panel (TRP)⁷ processes, and monitor systems investments in a harmonised way.

For immunisation and the GAVI Alliance: The above would benefit immunisation programmes by increasing resources available for the systems components of new

⁶ This resolution also endorsed support for nationally owned health plans aiming towards universal coverage; available at http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R12-en.pdf

⁷ The TRP is an independent and impartial panel of international experts of health and development, recently strengthened for gender expertise. The composition covers expertise in HIV/AIDS, TB, Malaria and cross-cutting issues. TRP members are appointed by the Global Fund Board

FOR INFORMATION

vaccine introduction, which are substantial. This would also increase sustainable access to vaccines and other child health interventions, in a more holistic manner by ensuring that immunisation specific outputs are key deliverables of health service strengthening efforts approaches to delivery.

In summary, the main differences between the existing ways of providing support and any future support would be:

- i) Countries should not have to negotiate separately with three or more 'global' funders;
- ii) Funders could agree to using one format as the framework for providing funding. This could be the national health plan
- iii) The agencies would agree to one assessment process. If the GAVI and GFATM boards agree to a fully harmonised approach, any application/proposal could be dropped in favour of a 'covering letter' to the national plan for HSS support;
- iv) One monitoring and evaluation system will be used;
- v) Funding would be provided in line with country planning and budget cycles.

Process

Details of potential mechanisms have been presented to the PPC in January, June, July, August, September and October 2009. In addition, the PPC convened a group of special HSS advisers⁸, who have also helped shape the design. A GAVI/GFATM/World Bank team has been in close contact throughout this whole process. It has also been informed by inputs from the World Bank and WHO, as representatives on the PPC.

The paper has been aligned, as far as possible, with the paper going to the GFATM Board meeting and will reflect the same options as outlined in the GFATM Policy and Strategy Committee (PSC) paper that will be presented in late September.

The final Board paper will also be informed by six complementary pieces of work:

- i) *Midterm evaluation of the GAVI HSS programme*. This will be available by 28 September;
- ii) *GAVI HSS tracking study of six countries*. This gives information on implementation of GAVI HSS at sub national level, using country-selected indicators in six countries⁹; this will be available by 30 September.
- iii) *Lessons learned*. A paper provided by the GAVI HSS Task Team. This will be finalised following the HSS Task Team meeting on 6/7 October.

⁸ Salif Samake (Mali), Claude Sekabaraga (Rwanda), Lola Dare (Nigeria), Faizullah Kakar (Afghanistan), Ian Pett (UNICE), Francesca Boldrini (Novartis), Dan Kress (Gates), Bob Emrey (USAID), Julia Watson (DFID)

⁹ Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Nepal, Vietnam, and Zambia

FOR INFORMATION

- iv) A review by GAVI HSS Independent Review Committee (IRC) members of how the IHP+ Joint Assessment of National Strategies (JANS) tool and common monitoring framework could be applied for joint programming (26 country national health plans), from the GAVI perspective. This will be presented to the IHP+ core team¹⁰ before finalisation.
- v) *A review of the GAVI annual progress report and monitoring processes, undertaken in early October; and*
- vi) *Consolidated feedback from key stakeholders (mainly countries).*

Country consultations: This is an ongoing process. There has been some joint representation at the WHO Regional Committee meetings in AFRO (GAVI/GFATM/World Bank), SEARO (GAVI/World Bank), EURO (GAVI/GFATM). Consultations at EMRO and WPRO meetings are to follow.

In addition, 4-5 countries¹¹ to potentially support in 2010 will be selected, and then over time, possibly up to the 49 Low Income Countries¹².

Next Steps

- At the face to face meeting on 1 October, the PPC will be requested to give guidance on: i) Two options for a joint HSS programming platform including performance based funding mechanisms ii) The layout, format and potential annexes required to give the board adequate information.
- The Board paper will incorporate further PPC comments, reflections from the GFATM Policy and Strategy Committee (PSC), results from the six complementary pieces of work noted above and experiences with countries, as well as any final HSS task team lessons learnt conclusions.
- The GAVI (17/18 November, Vietnam) and GFATM (9/10 November) Board papers on joint HSS will present the same options.

¹⁰ The core team is based in three locations - WHO Geneva, World Bank Washington, DC, and WHO Brazzaville (as part of the HHA Initiative). The IHP+ Core Team oversees and supports day-to-day operations related to the IHP+ work-plan at the global, regional and country levels. The inter-agency IHP+ Core Team is responsible for coordinating the efforts of the international health agencies and the required support for the country inter-agency 'health sector' teams

¹¹ Nepal, Ethiopia, Kyrgyzstan, either Afghanistan or Liberia and Malawi, Mali or Mozambique have been suggested

¹² GFATM (140 eligible), GAVI 72 eligible and WB (78 IDA eligible) work in many more countries