

**FOR DECISION**

GAVI initiated investments in HSS in 2006, to tackle critical bottlenecks in vaccine delivery, and to ensure sustainable integrated delivery of new vaccines. In December 2007, November 2008 and June 2009 the GAVI board endorsed further exploration of ways to strengthen HSS investment. The High Level Task force on Innovative Financing, the World Bank and WHO responded positively to an initiative by the CEOs of GAVI and GFATM, to explore the setting up of a joint HSS programming platform.

The GAVI Board requested that the Programme and Policy Committee (PPC) advise the Board on the joint platform. The PPC appointed a team of health system advisers to support the process, and oversaw the Secretariat's work.

The PPC and Secretariat recommend that the Board:

1. **Accept** applications for HSS support in 2010 against two performance based alternatives for countries to choose from for the joint funding and programming for Health Systems Strengthening (HSS) by GAVI, Global Fund to fight AIDS, TB and Malaria (GFATM) and World Bank (WB):
  - Alternative 1: Single HSS Funding Proposal. This harmonises the processes between GAVI and GFATM (and indirectly the World Bank). Countries would apply against one form, with one set of guidelines for HSS. There would be one HSS review panel drawing its membership from both GAVI IRC and GFATM TRP. WB has different processes and does not need a proposal, or a separate review process, but any application would be fully integrated with WB country financing.
  - Alternative 2: Country based. Fully harmonised and aligned, based on a jointly assessed single National Health Plan, using an annual review process and, agreed monitoring and evaluation framework. Independent appraisal would take place in country, with participation from members of the joint HSS panel members.

These alternatives have been developed in close collaboration between GAVI, GFATM and WB, with technical support and facilitation by WHO, under the guidance of the PPC. The GFATM Programme and Strategy Committee (PSC) has also provided input. The country context will determine which alternative could be used. Alternative 2 could be rolled out in 4-5 countries in early 2010. Alternative 1 is dependent on progressing quickly on harmonising processes between GAVI and GFATM. However, both require a board decision, as policies, systems and procedures would need to be modified.

Furthermore, the Board is requested to:

2. **Stop** accepting country applications using existing HSS guidelines. This would enable more prudent financial management and to give time to incorporate lessons learned from the evaluation and other studies. HSS applications already in the pipeline (ie, those submitted for October IRC session and those having received conditional approval in the Spring 2009 IRC session) would be honoured, subject to the availability of funds and that issues raised in the evaluation are addressed. Countries applying for continuation of funding, or new funding, could apply under the new joint platform. Lessons learned will be incorporated into existing HSS grant management as appropriate.

**FOR DECISION****Potential joint GAVI, GFATM and World Bank health systems strengthening programming and funding platform****1. Introduction**

Through opening the original HSS window, GAVI had already recognised the importance of HSS for overcoming some of the key bottlenecks to providing new vaccines, for supporting routine immunisation, and the integrated strengthening of maternal, reproductive and child health services. GAVI HSS support has been used for critical service focused interventions – training and supporting health workers, supporting logistics, surveillance and monitoring and evaluation. HSS support is one of the essential underpinnings to scaling up towards progress on the MDGs. Without HSS support the GIVS vision will be constrained. GFATM also supports HSS, primarily focused around its key areas of HIV/AIDS, TB and malaria. The World Bank has been providing HSS support over many years, but with a focus also on what might be considered more 'upstream' support to governance, financing, and inter-sectoral linkages.

The global landscape has also changed, with initiatives such as the International Health Partnership gaining momentum, and becoming, for several countries, the framework within which HSS support is provided. The Board recognised the opportunities for GAVI provided by these developments, most recently the High Level Task Force on Innovative Financing, and asked the Programme and Policy Committee to guide the development of further work. At the same time, GAVI had already commissioned several pieces of work to help guide and inform its investments in HSS. This has all come together to shape the future of HSS in GAVI.

This paper is inevitably a distillation of a huge amount of input. It has been developed following several PPC meetings, and results from consultations with countries, other stakeholders, and detailed discussions between GAVI, GFATM, World Bank, facilitated by WHO. It covers background and context, and outlines the potential and purpose of HSS joint programming, particularly focusing on advantages for GAVI. It describes the two alternatives under consideration in more detail. Both alternatives might be used, depending on the country contexts.

The paper provides more background on monitoring and evaluation, and performance based funding. It also covers, very briefly, how funds might flow. This is currently subject to much more discussion. Responding to evaluation findings it considers the role of technical support. It finishes with a discussion on challenges. Depending on the Board decision, next steps become critical. These decisions would imply some fundamental changes to the GAVI business model. These would need to be clearly communicated to countries, who are rightly concerned about any further changes. It needs to be clearly communicated that this should be a real improvement. Countries should be able to access funding in more accessible ways. In many cases, existing country systems would be used. Where that is not possible, there would only be one application process for HSS.

**FOR DECISION**

The HSS funding has potential to leverage new resources. Working with GFATM, World Bank, and others, also has many advantages in tapping into the comparative advantage of other organisations, and gives an opportunity to work jointly for maximum impact.

**2. Background**

Details of potential mechanisms for better supporting HSS were presented to the Programme and Policy Committee (PPC) in January, June, July, August, September and October 2009. The PPC convened a group of special HSS advisers, who have helped shape the design of the different iterations of this paper. The issues and alternatives outlined in this paper are jointly being presented to the GAVI and Global Fund to fight AIDS, TB and Malaria (GFATM) November boards. The World Bank does not need to put this to the Board, but has been fully involved, as has WHO as facilitators of the process.

The current work was stimulated by a joint letter from the Chief Executives of GAVI and GFATM to the chairs of the High Level Taskforce on Innovative Financing<sup>1</sup> (HLTF), an initiative that was also warmly welcomed by the President of the World Bank, and the Director General of WHO. As requested at the May meeting of the HLTF, and taking into account the 23 September HLTF feedback meeting to the UN General Assembly<sup>2</sup>. It builds upon ongoing work in the IHP+, the GFATM National Strategy Applications (NSA), and conclusions of meetings on joint programming in Washington<sup>3</sup> and Geneva<sup>4</sup> in June and August respectively, which included inputs from the World Bank and WHO.

This work 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* (which include programme specific strategies, M+E frameworks, budgets and annual implementation plan, 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 at country level.

Whilst this paper focuses on the joint funding platform between GAVI / GFATM / WB, other agencies, notably WHO, UNICEF, UNFPA, UNAIDS, other H8 agencies, and bilaterals, have key roles to play, particularly in technical support provision, or funding.

<sup>1</sup> See page 22 of the report [http://www.internationalhealthpartnership.net/CMS\\_files/documents/taskforce\\_report\\_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf)

<sup>2</sup> [http://www.internationalhealthpartnership.net/CMS\\_files/documents/un\\_general\\_assembly\\_meeting\\_outcome\\_document\\_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/un_general_assembly_meeting_outcome_document_EN.pdf)

<sup>3</sup> <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:22231443~menuPK:2643981~pagePK:64020865~piPK:51164185~theSitePK:282511.00.html>

<sup>4</sup> <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:22299073~menuPK:282516~pagePK:148956~piPK:216618~theSitePK:282511.00.html>

## FOR DECISION

The scope of this paper is necessarily limited to address the immediate opportunities, and challenges.

This Board paper is also informed by four other complementary pieces of work, which are outlined in annex 1. It is reassuring that all four pieces of work identify relatively common strengths and weaknesses. The findings very usefully support GAVI HSS as it goes through this redesign phase. Several recommendations have already been taken into consideration. For example: work started in 2009 on implementing Financial Management Assessments; there is a greater focus on monitoring and there is a greater focus on technical support mechanisms (reviewed both by GAVI and GFATM in the last year). In summary the four pieces of work include:

- a) *GAVI HSS midterm evaluation*: This looked broadly at HSS, covering 21 countries. It states that ‘the decision to tackle health systems barriers was a good one’. The issues raised are not with the concept, but with some of the processes. It highlighted several strengths including: flexibility, easy to use, addressed country needs; proposal design relatively straight forward and inclusive. However several weaknesses were identified that included: weakness in the design of monitoring and financial management, variability and poor quality of technical support provided to countries particularly on implementation; lack of intimate knowledge of implementation and financial consequences at country level and greater need to learn and manage knowledge.
- b) *GAVI HSS tracking study*: This study looked in more depth at six countries. It looked at the sub national level<sup>5</sup>. It also highlighted the need to be context specific. Countries cited the need to report directly on GAVI implementation as a barrier to putting GAVI funds into pooled funding mechanisms. Procurement issues were highlighted as lacking standardised approaches and the need for greater engagement with civil society and private sector was highlighted as a priority at all stages of the process.
- c) *Lessons learned*. A paper provided by the GAVI HSS Task Team backed up many of the recommendations made in the evaluation and tracking study. It gives an outline of issues and recommendations that centre around the application process, technical support (need to prioritise implementation and monitoring, not just grant writing), governance, harmonisation and alignment, and other issues, e.g. financial management.
- d) *Review by GAVI HSS Independent Review Committee (IRC) members of how the IHP+ Joint Assessment of National Strategies (JANS) tool and common monitoring framework*: This desk review of 26 countries endorsed that the current tool and common monitoring framework are sufficiently robust for the GAVI Alliance to use in the joint HSS platform. Several minor changes were suggested and the IHP+ core team is considering this work in its next iteration of the JANS tool.

---

<sup>5</sup> Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Nepal, Vietnam, and Zambia

## FOR DECISION

*Current status of GAVI HSS:* Of the \$800 million budget envelope approved for HSS<sup>6</sup>, \$525 million has, to date, been committed for 45 countries in multi-year grants varying from 1 to 7 years (maximum up to 2015). Support for the implementation and monitoring of these investments should be strengthened and guided by the recommendations made in the mid-term evaluation and tracking study. See Annex 2 for the status on which countries have applied for funding, and which might come forward in 2010/2011. The Secretariat is recommending that unused funds in this window, as of end Dec 2009, should be reprogrammed to GAVI's core resources.

### **3. Purpose, principles, potential and overview of a joint HSS platform**

The primary stakeholders are people living in eligible countries. Better health outcomes, including health MDGs and the Global Immunisation Vision and Strategy (GIVS) are the main aim. Significant investment is needed to overcome bottlenecks, to better integrate services and to ensure much better complementarity of internal and external investments.

Health system bottlenecks identified in GAVI HSS proposals include adequately identifying and reaching people; recruiting, training and retaining staff; basic logistics needed for delivery; and supervision and monitoring. External financing is a variable part of the funding picture, but in most countries, overwhelmingly, the bulk of resources come from domestic resources. Civil society and the private sector are significant providers of health services in many countries, and have roles to play well beyond the provision of services, in experimenting with innovative approaches, in advocacy with government and in ensuring that the most vulnerable groups gets access to services.

#### 3.1 Purpose

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

#### 3.2 Principles

*Principles:* A joint GAVI –GFATM- WB funding and programme HSS platform would take account of the following principles<sup>7</sup>, which have been discussed by the PPC:

- **Differentiated approach:** There is no 'one size fits' all solution. Countries vary in both needs and requirements. Fragile states<sup>8</sup>, 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.
- **Common frameworks for assessment, approval, implementation and monitoring,** that use performance based mechanisms. This will result in shared

<sup>6</sup> At the December 2005 and February 2008 Boards

<sup>7</sup> These principles are based on feedback from the PPC, and from the 20/21 August meeting in Geneva

<sup>8</sup> <http://www.oecd.org/dataoecd/14/14/43293581.pdf>

## FOR DECISION

- analysis, common frameworks for approval<sup>9</sup>, 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 immunisation specific 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 Countries<sup>10</sup>, as highlighted by the HLTF. 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. 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.** Flow through auditable and accountable fiduciary mechanisms;
  - **Technical support.** . The need for high quality, impartial, technical support is acknowledged, but this needs to be demand driven, harmonised and transparently provided.

### 3.3 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 and potentially shift this 'headache' to global level donors. It will improve coordination, and will likely leverage additional resources. The outcome of the High Level Taskforce on Innovative Financing was presented at the UN general assembly on 23<sup>rd</sup> September<sup>11</sup>. The UK, Australian and Norwegian governments all advised of their intention to increasing funding (specifically for HSS) available through the International Financing facility for Immunisation (IFFm) by \$1 billion. It is therefore crucial that the design of such a platform aims to achieve sustainable, measurable results. The mechanisms of fund flow will need to be worked out in consultation with the countries.

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 and need to take other components of the health sector into consideration (such as reproductive and maternal health). It is consistent with the objectives outlined in the 2009 World Health Assembly resolution on primary health care and health systems strengthening<sup>12</sup>. This focus on HSS could lead to significant benefits for immunisation and the GAVI Alliance. Resources will be increased, which will support the systems costs of new vaccine introduction, which are substantial. This would also increase

<sup>9</sup> In the case of the World Bank this refers to the project preparation process.

<sup>10</sup> GFATM (140 eligible), GAVI 72 eligible and WB (78 IDA eligible) work in many more countries

<sup>11</sup> Available at

[http://www.internationalhealthpartnership.net/CMS\\_files/documents/un\\_general\\_assembly\\_meeting\\_outcome\\_document\\_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/un_general_assembly_meeting_outcome_document_EN.pdf)

<sup>12</sup> 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](http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R12-en.pdf)

## FOR DECISION

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

- Significantly **reduce health systems bottlenecks** which hamper the introduction of new vaccines, and the delivery of routine immunisation programmes. Leverage **new resources** for health, including introduction of new technologies such as new vaccines, focused on, but not limited to MDGs 4, 5 and 6;
- 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 duplication and increase harmonisation;
- Reduce **fragmentation** in health systems support thereby reducing **transaction costs** for countries and partners, i.e no more donor specific reports;
- Reduce **fiduciary risk**, with more transparent oversight by in-country partners. This is an important issue 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, and potentially with others. It could join GAVI Independent Review Committee (IRC) and GFATM Technical Review Panel (TRP)<sup>13</sup> processes, and monitor systems investments in a harmonised way.

### 3.4. Overview of the joint platform

There are already good examples of joint work between the three funding agencies, and with others. But a step change is needed. Current working practices have to significantly change. GAVI, GFATM and WB have increased the volume of resources for health and AIDS, which is very welcome. But it has come at some cost. The primary intent of the joint HSS platform is to refocus the transaction costs incurred by countries, to funders. And, to ensure that programming and funding is aligned with national health planning and budget priorities and cycles. This responds directly to one of the main criticisms of GAVI HSS support to date.

*Planning, prioritising and budgeting cycles:* Currently the GAVI and GFATM application and HSS disbursement does not necessarily align with country planning, budget and review cycles. The investments might not be on budget, leading to misalignments and skewing of health budgets. This initiative will bring joint HSS support in line with countries' own cycles, priorities and review progress at a time that fits in with country processes.

---

<sup>13</sup> 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 DECISION**

*Overview of in-country planning processes;* This is outlined in the annex and is basically the starting point for joint funding platform. The joint platform should build upon these existing processes and should not generate any new processes or work for countries.

*Civil society and private sector:* Civil society and the private sector play key roles in delivering, planning and advocating for healthcare. GAVI now has an opportunity to ensure that there is increased engagement with national planning, implementing and monitoring processes. The current version of the JANS tool stipulates the need for CSO and private sector engagement. Efforts will need to be made to ensure that CSOs receive necessary support for countries to achieve national health goals. National planning does not just mean support to governments.

*Defining what would be considered for funding:* The current conceptual framework for defining health systems remains the six WHO recommended building blocks<sup>14</sup>. Bottlenecks need to be identified, and there needs to be common understanding of what is meant by a National Health Plan, and a common understanding of what is subsequently being assessed and appraised for funding. For the purposes of the joint platform, a National Health Plan comprises the four elements:

- i) a broad overall National Health Plan;
- ii) a programme specific or department specific strategy or plan;
- iii) an M+E framework (that may be incorporated into the plans or strategies or may be separate and,
- iv) a rolling plan or annual implementation plan .

*Independent element:* Without a country presence, GAVI and GFATM rely currently on independent bodies to make funding recommendations. ToRs and possible membership of an independent group of experts who could represent the GFATM and GAVI at either country or regional level is being drafted. Some individuals from the group could take part in the joint assessment process. The Boards would still make the funding decisions. Only after a funding decision is taken, and a Financial Management Assessment is conducted, could GAVI sign a country level compact.

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

- i) countries should not have to negotiate separately with three or more 'global' funders;
- ii) funders agree to using one format as the framework for providing funding. This could be the national health plan
- iii) funders 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

<sup>14</sup> <http://www.who.int/healthsystems/topics/en/>

**FOR DECISION**

- vi) A harmonised, sustainable country driven approach to the provision of technical support be established.

**4. Two alternatives for developing a platform for joint HSS programming**

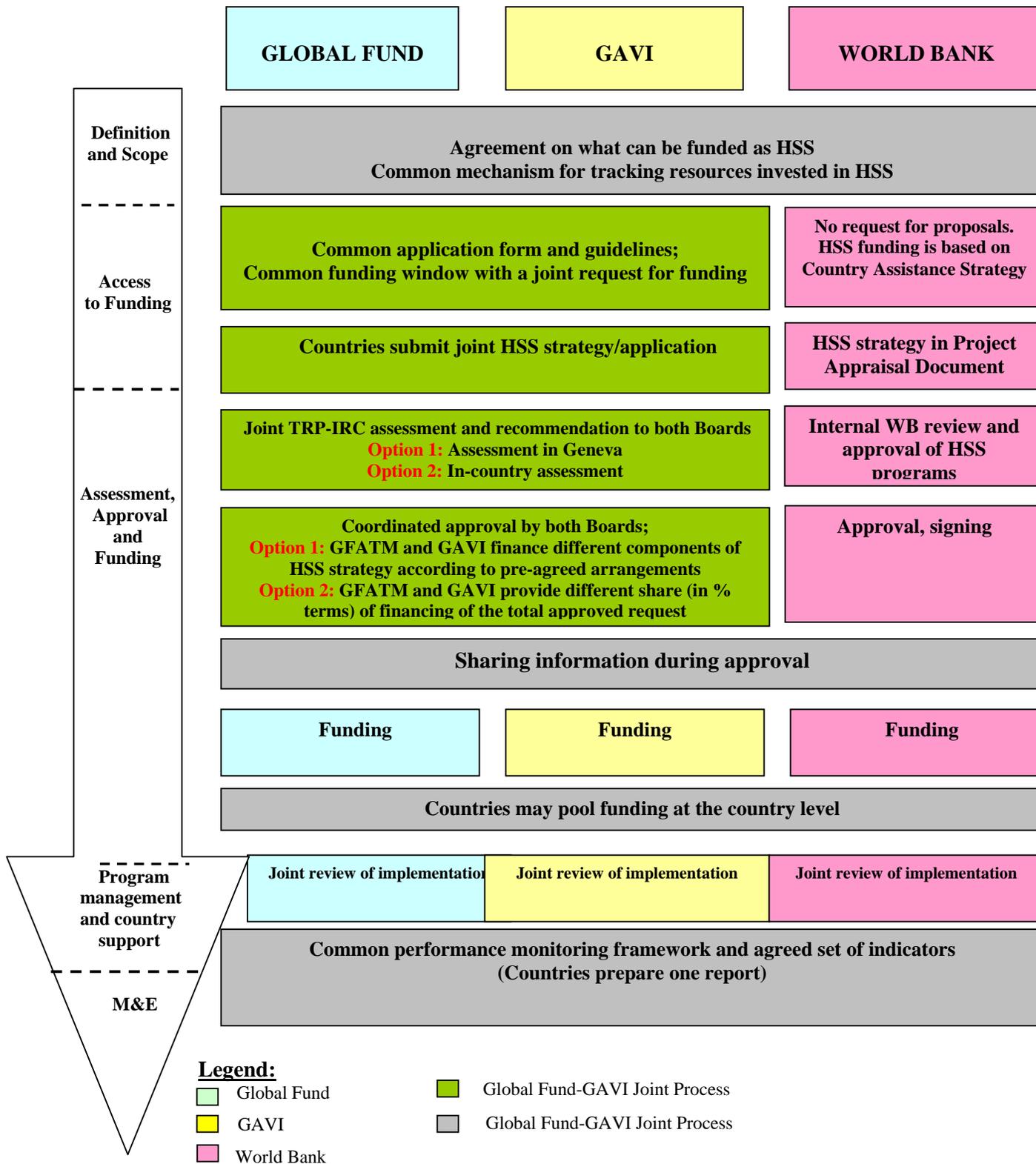
The two alternatives presented below could both be used for funding HSS, but will depend on the country context. Some countries already have well developed national plans (and could put forward a request for alternative 2), others might need an approach that is more 'project-like' (alternative 1). The two alternatives are represented diagrammatically below. Since alternative 2 departs the most from existing GAVI structures and policies, it is expanded on the most. Alternative 1 is more specific to GAVI and GFATM, but it would be harmonised as far as is possible, with the World Bank processes.:

**Alternative 1: Single HSS Funding Application; and  
Alternative 2: Fully harmonised and aligned, based on jointly assessed National Health Plans and strategies****4.1 Alternative 1: Single HSS Funding Application**

- i. GAVI and GFATM agree the same countries, the same timing and the same scope for HSS support (what is fundable). There is a single proposal screening and review process. The single proposal would be approved (or not) as per respective Board requirements. The issue of whether 'rounds' continue, or whether applications could be considered more continuously needs to be discussed
- ii. The appraisal could take place either in Geneva, or in-country. Separate funding streams and separate grant management would result, but there would be one monitoring framework which is jointly agreed;

**FOR DECISION**

**Alternative 1: Single HSS Funding Request**



iii. The implications for existing policies might include the following:

**FOR DECISION**

- a) Continue a separate funding window for HSS;
  - b) Decide on the scope of HSS activities, in order to harmonise with GFATM and the WB;
  - c) Revisions would likely be required to the 'rounds' system by GAVI and GFATM;
  - d) Agreement is needed on the entity that would submit the joint funding request at the country level;<sup>15</sup>
  - e) Inter-agency arrangements would need to be developed on responsibilities for managing the entire access-to-funding process;<sup>16</sup>
  - f) A joint review mechanism would bring together the Independent Review Committee (IRC) and the Technical Review Panel (TRP, GFATM);
- iv. *The benefits of this approach might include the following:*
- a) Significantly reduced transactions costs. There would be a single funding application. Countries manage fewer grants with lighter reporting requirements;
  - b) It would result in significant harmonisation of the global health aid architecture;
  - c) Reduced risk of duplicative funding.
- v. *The limitations and risks of this approach might include the following:*
- a) The complexity of bringing together the access-to-funding process and related policies. This option would be likely require the GFATM to revise a number of policies;
  - b) Countries have just got to grips with multiple requirements, is this something new again?

#### 4.2 Alternative 2: Fully harmonised and aligned, based on jointly assessed National Health Plans and strategies

The three funding agencies are not starting from scratch. There is already experience with existing HSS. The IHP+ discussions have focused on many of the practical issues in detail. Other agencies and bilaterals have been in the external funding environment for much longer, and have a wealth of experience on which to draw. Above all, the countries have now had up to seven or so years experience of global funding instruments supporting health systems.

Joint GAVI, GFATM and WB work has recently focused on the extent to which processes need to be further **coordinated**, **harmonised** (adjusting tools processes and systems), or **integrated** (replacing existing systems with shared new ones)<sup>17</sup>. The steps and processes below need to be considered. Some steps are concurrent, some sequential. The order below is not necessarily significant, but includes:

<sup>15</sup> Currently for the Global Fund this is the Country Coordinating Mechanism (CCM) and for GAVI this is the broader overall Health Sector Coordination Committee (HSCC). The entity would need to include the principles of inclusion, partnership and country ownership.

<sup>16</sup> This would include the development of joint materials, communicating with countries, managing the review body, providing a screening process, and managing the review process itself. This could be in the form of a joint HSS secretariat for this purpose, or alternatively one of the agencies to provide these functions on behalf of the other two.

<sup>17</sup> <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:22299073~menuPK:282516~pagePK:148956~piPK:216618~theSitePK:282511,00.html>

**FOR DECISION**

- i) *Drafting national plans and budgets and developing a common monitoring framework*<sup>18</sup>. Needs assessment, including identification of key health systems bottlenecks. Detailed strategies are embedded in the national plan. It should be a country owned, inclusive process which allows Civil Society Organisations (CSOs) and others to engage with planning processes to achieve overall health objectives;
- ii) *Common assessment of plans and budgets by government, stakeholders and partners*, based on an adapted version of the IHP+ joint assessment tool (JANS), or other mutually agreed process<sup>19</sup>;
- iii) *Allocation of HSS budget by agencies, and policies for announcing fund availability*. There needs to be consideration of what happens at country level (pooled or projectised), and globally. GAVI has an HSS 'window', GFATM has different processes (integrated into disease specific proposals, or cross-cutting), and WB allocations determined in the project preparation process, but no 'windows';
- iv) *Funding request (application process)*. There are currently separate technical guidelines or principles to guide countries who wish to access HSS funding. The guidelines and proposals vary considerably in terms of content (and length). The WB has a project preparation phase, but no separate proposal;
- v) *Application screening and review*. The screening process is currently an IRC for GAVI, Technical Review Panel (TRP, GFATM) or the World Bank management process. For GAVI and GFATM a funding recommendation is made to the boards. One option is to shift the screening process to country level, once a national health plan has been jointly assessed and the national health plan 'appraised' for funding by donors.
- vi) *Approval of funding request by GAVI/GFATM boards and WB* to ensure multi-year funding commitments are made and compacts (where appropriate) are agreed upon. This would be on the basis of recommendations from the appraisal group and made by Board level Grant negotiation and disbursement follows.
- vii) *Programme implementation and supervision*. This includes issues of procurement; monitoring and evaluation; access to technical support and operations research.

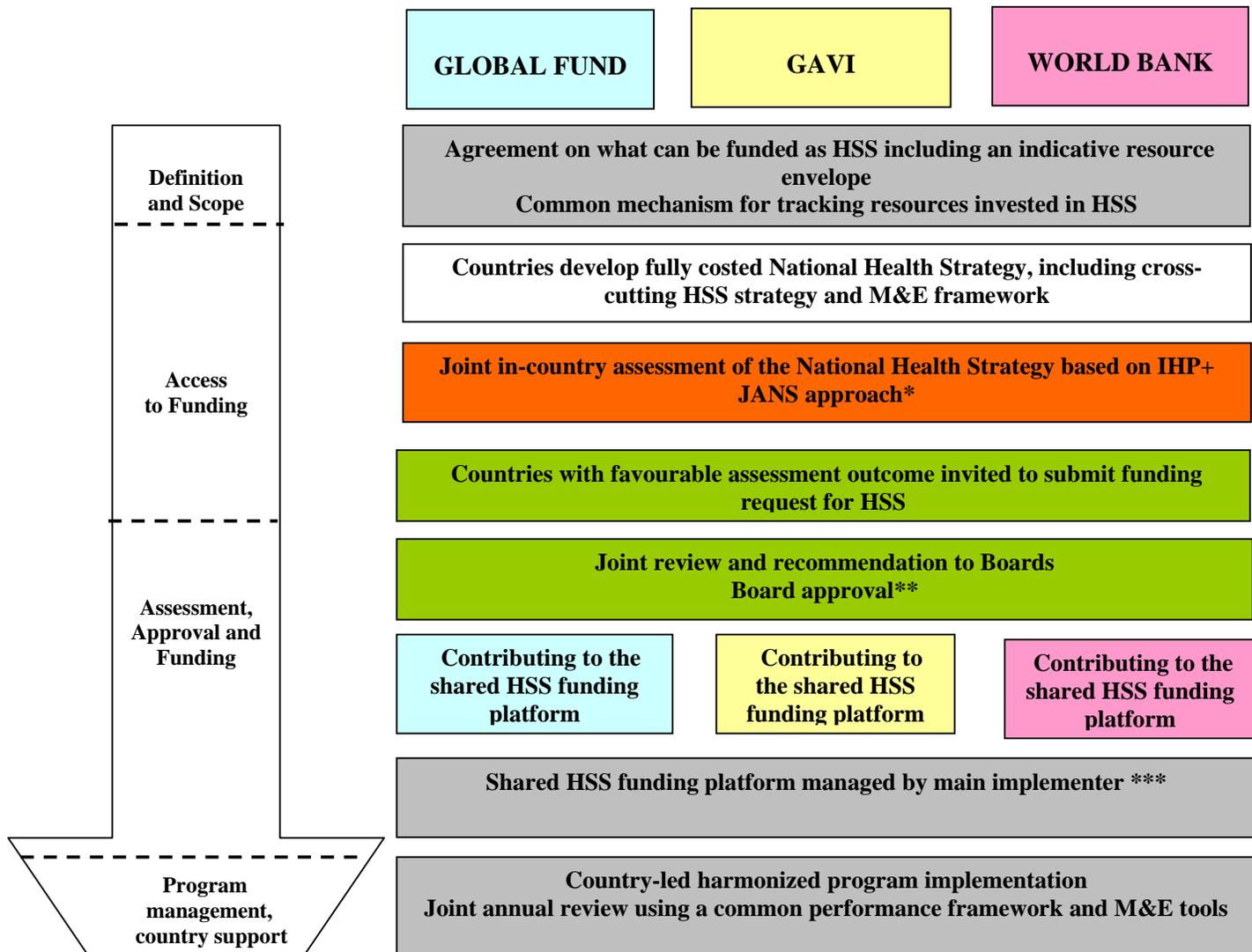
---

<sup>18</sup> These could include an overall national health plan with budget, programme specific plan and budget, monitoring and evaluation plan and an annual rolling plan

<sup>19</sup> It is early in the IHP process with common assessment, so, pragmatically, while this could be the ideal case scenario, assessment cannot be held up in the interim. The JANS tool will require adjusting over the coming months, on the basis of visits to 3 countries

**FOR DECISION**

**Alternative 2: Funding Based on Jointly Assessed of National Health Strategies**



**Legend:**

- Global Fund
- GAVI
- World Bank
- Countries
- Global Fund-GAVI Joint Process
- Global Fund-GAVI-WB Joint Process
- Global health partners (multiple stakeholders)

\* If the country has already been through an agreed JANS process that includes the three agencies, there would be no separate assessment

\*\* The independent element for recommending funding could be incorporated through having some of the HSS pool (former IRC/TRP HSS experts) participate at country level

\*\*\* In Global Fund terms, this is the Principal Recipient (e.g. Ministry of Health)

**FOR DECISION****Summary of issues for alternative 2:**

- i. No specific HSS proposal. Instead, funding decisions would primarily be made on the basis of jointly assessed national health plans.
- ii. The concept represents a departure from current modalities. It involves funding a national health plan/strategy where the HSS elements may or not be distinct. For the World Bank there is no real change.
- iii. The implications for existing policies might include the following:
  - a) A revision of GAVI and GFATM policies would be required in order to allow funding on the basis of a national health plan / strategy;
  - b) An in-country assessment and appraisal process (including an independent element). Funding ceilings might be required in order to guide the size of the funding request from countries. This would require changes to the GFATM Policies but GAVI could stick with its HSS budget ceilings - or consider using a new algorithm performance based design mechanism.
  - c) A harmonised PBF framework would be required. The Board would need to agree in principle to direct resources into national health sector budgets, with links to specific programme outcomes measured in a common monitoring framework.
- iv. The benefits of this approach might include the following:
  - a) Significantly reduced transaction costs. No specific HSS funding proposals. Funding decisions would be based on existing documentation.
  - b) A strong incentive to develop strong nationally owned and comprehensive national health strategies, as these would be linked to a funding envelope.
  - c) The profile of immunisation is raised to overall health plan level and more holistic consideration of new vaccine introduction undertaken;
  - d) This process could be closely aligned with IHP processes in countries. Countries could expand this to incorporate others who are willing to fund on the basis of jointly assessed national health strategies.
  - e) If accompanied by the creation of an 'upstream pool' of funding for HSS, this would represent a major harmonisation of the global health aid architecture, and create a mechanism by which to channel any new funds arising from the HLTF or from other sources.
  - f) Countries are in a stronger position to guide harmonised technical support mechanisms.
- v. The limitations and risks of this approach might include the following:
  - a) This option assumes that national health plans and associated strategies contain sufficient detail on HSS to form the basis for funding decisions. The review by IRC members suggests that there is sufficient detail in National Health Plans, but this needs to be tested.
  - b) It could be seen as a dilution of GFATM's or GAVI's mandate;

## FOR DECISION

- c) There might need to be two different reviews. The first comprising an assessment (essentially a technical review) of the national health strategy and accompanying documents. The second is an appraisal of the funding request (assessing the financial gaps and need). This would be inefficient. Depending on the context, it might be possible just to have one review.

It is proposed that any applications for GAVI HSS from 2010 use one of the two alternatives highlighted. This would be consistent with recommendations from the HSS evaluation. Efforts should be made to ensure that delays between funding tranches and for initial disbursements that may affect predictability are minimised. If the board approves the recommended alternatives, this will mean GAVI HSS support will be within the joint platform and will give time for:

- recommendations made in the evaluation and tracking study to be incorporated into the design;
- adequate technical, financial and programme support mechanisms<sup>20</sup> to be built up;
- outstanding FMAs to be conducted for existing commitments

This will also simplify the monitoring of investments and approach to countries, with one mechanism used for new applications up until end 2009 and a newly designed support from 2010 that incorporates various recommendations. It will therefore be crucial that clear communication is given to countries as soon as possible after the board meeting.

### **5. The future of the current GAVI HSS programme**

Existing commitments total approximately US\$ 525 million. To take account of evaluation findings, and to take advantage of the possibilities of a new platform, it is recommended that no new applications be sought under the existing system. And, work is undertaken to 'retrofit' grants as far as possible, particularly in taking account of recommendations of ensuring adequate implementation technical support, and support to developing adequate outputs and outcomes.

### **6. Eligibility**

To ensure standardisation between the three funding agencies and to remain consistent with the HLTF recommendations, the joint funding platform would apply to countries defined by the World Bank as 'Low income'. Currently this includes 49<sup>21</sup>, but will be revised on an annual basis. This differs to the decision being taken on overall GAVI eligibility. The Board should be aware that some previously eligible countries might not be eligible for joint programming HSS support (see Annex 2).

---

<sup>20</sup> Within the secretariat, at global, regional and country levels by partners

<sup>21</sup> This is the 2008 classification

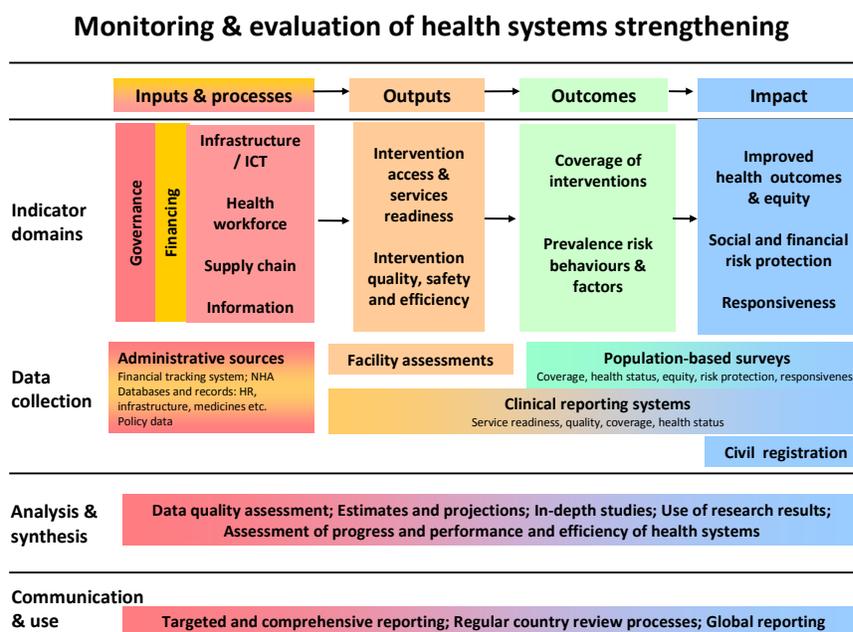
## FOR DECISION

### 7. Common monitoring and evaluation framework to ensure HSS support is performance based and based on IHP+ principles

The IHP+ common evaluation framework will be used to monitor and evaluate HSS joint programming. The common evaluation framework builds upon principles derived from the Paris declaration: alignment with country processes, balance between country ownership and independence, harmonised approaches using international standards, capacity building and system strengthening, collective action and adequate investment.

As shown below, the framework outlines the stepwise progression from inputs and processes to outputs, outcomes and impact. Impact is broadly defined here as including not only reduced mortality, but also reduced morbidity, improved equity and protection from social and financial risk. Specific monitoring and evaluation actions related to data collection, analysis, synthesis, communication and use are summarised along the bottom of the framework. Immunisation-related measures are captured in multiple places in the framework. Immunisation coverage is included under “outcomes.”

**Figure 1**



#### 7.1 Operationalising the framework

A platform—country health systems surveillance (CHeSS)—is being developed to make this framework operational at the country and global levels. CHeSS aims to improve the availability, quality and use of data needed to inform annual health sector reviews and planning processes and to monitor health systems performance at the country and global levels. Data used to track progress in implementation of HSS joint programming will be synthesised on the CHeSS platform from three primary sources:

**FOR DECISION**

1. Country financial reporting: amount received and spent on HSS programming.
2. Country performance reporting: based on country's national M&E plan for the health sector.
3. Additional performance indicators: synthesised from supplemental, existing sources.

*Country financial reporting:* Countries receiving financial support through HSS joint programming will report annually on the amount of funds received for HSS programming from different sources and the breakdown of how those funds are used.

*Country performance reporting:* The starting point for monitoring of country performance will be the existing country M&E plan that is part of the national health plan. Work is underway to develop a list of 50 core indicators with standard definitions and recommended data sources that all countries will be encouraged to include in their national M&E plans.

*Additional performance indicators:* If all country M&E plans contained all performance indicators that partners supporting HSS needed to track on a regular basis, there would be no need for additional performance measures beyond those already included in country M&E plans. But, in some instances there might be a need for some more in-depth indicators. Taking immunisation as an example, every national M&E plan will already include indicators of immunisation coverage, infant mortality and under-five mortality among the core set of priority indicators measured and reported against on a regular basis. However, many other immunisation-related indicators of importance to GAVI and others—including countries—will not be included in the core set of priority indicators included in country M&E plans. The following is a list of illustrative areas where GAVI and others will track country progress, but which are not included in all country M&E plans. Note that these are not indicators, but areas in which specific, appropriate indicators will be used to measure country progress over time.

1. Incidence of vaccine preventable diseases
2. Performance in introducing new vaccines (time taken to scale up new vaccines to coverage levels achieved with existing vaccines, effect of introducing new vaccines on coverage of existing vaccines)
3. Regional equity in DTP3 coverage (percentage of districts with at least 80% coverage)
4. Population equity in DTP3 coverage (poor vs. non-poor, female vs. male, other groups as appropriate)
5. Injection safety practices
6. Efficiency in use of vaccine supplies
7. Quality of immunisation-related administrative data (summary measures from Data Quality Audit, discrepancy between coverage estimates from administrative sources and household surveys)

An important characteristic of the CHeSS platform is its multi-purpose and multi-directional orientation. CHeSS represents not a platform for countries to report to global partners, but a platform to synthesise results from multiple sources to inform

## FOR DECISION

annual health sector reviews, country planning processes, country management of health strategy and the tracking of progress made under global initiatives, including HSS joint programming.

### 7.2 Linking financial support to performance

Provision of financial support for HSS will be based on country performance. Each year, performance will be reviewed at the country level during the annual health sector review. Decisions regarding the release of funds beyond an initial agreed upon period of time will depend on performance against targets.

Options are being explored for combining elements of the approach to performance-based support used by GAVI, GFATM and the World Bank. GAVI has historically provided performance-based support primarily through cash-based rewards for achievement of specified targets. These rewards are additional to a predictable package of financial and technical support provided to countries. GFATM has provided whereby the results of a review of country performance are used to inform a decision to terminate, accelerate or continue the level of support provided under a country grant agreement. The World Bank has provided support through buy-downs and performance-based contracting, among other means.

A merged approach may have the following characteristics:

- Each year, during the annual health sector review, the country and development partners review the level of progress made in the health sector, vis-à-vis a set of explicitly specified criteria
- Based on the results of this review, implementation in each country is classified as follows:
  - Unsatisfactory: financial support is suspended
  - Satisfactory: financial support continues per original schedule
  - Highly satisfactory: financial support may be accelerated, as appropriate
- In addition, countries deemed to have highly satisfactory implementation become eligible for flexible, cash-based performance-rewards given for the achievement of specified targets (e.g., increases in immunisation coverage, gains in equity of immunisation coverage or improvements in efficiency in use of vaccine)
- The cash rewards would be based on outcomes and targets agreed upon in advance and based on the national health strategy
- Checks and balances would underpin this system, including rigorous validity checks for any administrative data used and monitoring of adverse consequences, including possible gaming and distortions in reporting systems

In addition, countries may use HSS funds to support their own performance-based systems and initiatives, as described in their health strategies and plans. For example, countries that pay health workers or managers based on achievement of performance targets—and countries that deliver health services through performance-based contracting—may use HSS funds to help finance these systems and initiatives, as appropriate.

## FOR DECISION

A technical group consisting of monitoring focal points from GAVI, GFATM, the World Bank and WHO, as well as 3-4 members of the Interagency Working Group for Results-based Financing for Health, will further develop options for making HSS joint programming performance-based. Consultations with countries will be conducted to elicit country perspectives on options for making HSS support performance based. The options developed will undergo technical review by the Interagency Working Group for Results-based Financing for Health.

### **8. Joint funding mechanisms**

#### **8.1 In-country joint funding mechanisms:**

The case for in-country transparent, auditable and accountable funding mechanisms that include oversight by several in-country partners has already been made. These operate in a number of countries already through SWAps, or other mechanisms. This decreases fragmentation, and strengthens coordination. While financing is only one part of the SWAp mechanism, it does give reassurance of longer term predictable support for national health plans, tailored to country specific contexts and allowing for flexible arrangements varying on a year by year basis. As noted above, there is significant differentiation between countries. There will be a variety of responses at country level, with pooled funding the ideal, but still the possibility of more discrete approaches, particularly in post conflict and similar environments. Specific mechanisms for support to fragile states will be designed dependent on joint assessment.

#### **8.2 Global joint funding mechanisms:**

Existing funding now flows separately into different accounts in-country. At the very least, as described above, GAVI should be striving for pooling, if the TAP policy is complied with. In contrast to the WB, GAVI and GFATM funds would most likely focus at the service delivery level, with the aim of overcoming health systems bottlenecks to scale up access.

Longer term, depending on the wish of the various boards, there could be a pool of funding or elements of possible co-financing could be worked out, where the three entities receive a request for funding and decide to 'co-fund'. It could take streams of finance from various sources (expanded IFFIm, GFATM sources, WB etc), but the managers of these funds would be responsible for ensuring that the requirements of different boards were met within the different institutions. Countries should not have to worry about the source of funding for their HSS interventions, and should not have to cope with any additional requirements.

### **9. Harmonised technical support or capacity building**

Substantial amounts - more than 40%<sup>22</sup> - of international resources are spent on technical support. Technical support therefore represents an enormous opportunity for gains in efficiency and effectiveness. It is one of the key areas highlighted in the HSS

---

<sup>22</sup> The HLTF cites an estimate of 42% of all Development Assistance for Health between 2002 and 2006

## FOR DECISION

evaluation. Current technical support mechanisms are often fragmented, unsustainable, not necessarily responsive to country needs, of mixed quality and with no opportunity for countries to provide feedback. Much technical support in the past has been targeted for drafting quality proposals, rather than at implementation or monitoring. Various streams of work to ensure harmonised technical support is provided to countries accessing funding for HSS in 2010 is a high priority.

The IHP+ joint assessment process could provide an opportunity for countries to explicitly state what sustainable technical support or capacity building may be required. It also provides an opportunity for agencies to play to their comparative advantages when technically supporting countries. The WB has already set up technical hubs across Africa for such purposes.

### **10. Challenges and assumptions.**

#### **10.1 Challenges:**

As well as individual risks as outlined, several generic challenges exist:

*Inclusive approaches to developing national health plans:* commitment to including civil society and private sector and a broader ranges of stakeholders is essential.

*Selection of initial countries (including fragile state):* The HLTF highlighted the need to not just focus on countries with relatively strong health systems. These are challenging environments. Boards will need to weigh up their appetite for risk when operating in such environments. There is inherently a tension between harmonisation and tight accountability..

*Complexity of harmonisation between established funding entities:* The complexity of harmonising the processes between three different funding entities should not be underestimated.

*Criteria for budget envelopes per country:* Each funder has its own criteria for resource allocation according to needs and available resources. Decisions will need to be made about whether to 'ring fence' HSS budgets, and whether to apply per capita or other criteria. Agencies will also need to decide what proportion of funds to allocate to HSS i.e. whether to apply any 'ceilings' or proportions of overall health funding.

*Ensuring investment leads to programme (e.g. Immunisation) specific outcomes:* Immunisation outcomes have to remain in sharp focus. The IRC desk review has already identified the minimum suggested criteria for common monitoring indicators and adaptations to the joint assessment tool.

*Ensuring a performance based approach:* This will depend on the quality of annual national health sector reviews, and will depend upon the incentives and expectations built into the design process.

*Is there perceived competition for funding?* There are concerns that funding for immunisation (or AIDS etc) might reduce if there is too much focus on a "joint platform"

## FOR DECISION

for health systems. It should not be seen as an either/or situation, but as a necessary complement to actually achieving health results.

*Working coherently with multiple partners with different views on health systems:* This remains a challenge and often delays some processes, but focus on ultimate support for countries to achieve agreed health outcomes in their National Health Plans should help focus support on partners' comparative strengths (outlined in annex 1).

### 10.2 Key assumptions for achieving success

- Partners are equally committed to implementing the principles of the IHP+ (which includes examining the legal, financial and procurement processes in each supporting institution);
- There needs to be a sense of urgency, willingness to 'learn by doing', and board willingness to quickly adapt policies and procedures
- Whatever the definition of health systems strengthening, there is a recognition that strong health systems, based on primary healthcare principles of equity and solidarity are vital for achieving health outcomes;
- Existing or new resources are available to support systems components of jointly assessed national health plans; and
- The in-country coordination mechanisms (including civil society and inputs of other H8 agencies) take ownership of the new business model of a new health systems platform

## 11. Conclusion

The joint platform for HSS presents huge opportunities for providing direct support for funding gaps for immunisation in National Health Plans and decreases the fragmented nature of support they receive and for. There are potentially new resources available, if the joint platform is designed and can be operational in 2010. The design emphasises the need for common monitoring framework, performance based funding and harmonised approaches to technical support. There is reassuring evidence that the proposed joint assessment and common monitoring processes could be used by the GAVI Alliance, with some minor changes which will be further refined during country consultation processes. Any new support for GAVI HSS could be channelled through this mechanism, which means that recommendations made in the evaluation, tracking study and lessons learnt can all add to the robustness of the design before any new commitments are made to countries.

## 12. Next Steps after the board

*Communication:* Dependent on the board's decision, communication to countries regarding the future HSS application processes will need to be sent urgently.

*Redesign:* Recommendations made in the mid-term evaluation, tracking study and lessons learnt from the GAVI HSS task team will all need to be incorporated into the guidelines for future HSS support. Detailed work is required with GFATM, particularly to harmonise application processes. This is consistent with the ongoing GFATM architecture review.

**FOR DECISION**

*Performance Based Funding.* The technical group will further develop options for making HSS joint programming performance-based. The options developed will undergo technical review by the Interagency Working Group for Results-based Financing for Health.

*Creating a pool of HSS specialists.* If the Board decides to take this route, a pool of experts from the existing IRC and TRP should be convened, or new members proposed.

*Further consultation and selection of countries:* There are 4-5 countries that have already expressed interest in a joint assessment process - Nepal, Ethiopia, and Rwanda have all already requested a joint assessment of their national health plans and strategies. Vietnam, Liberia and Kyrgystan are all on track with GAVI HSS implementation and highly likely to apply for continuity of GAVI HSS funding. Opportunities need to be taken post-Board to further continue the consultation process, particularly to focus on the 'how' of the roll out.

*Further consultation with development partners.* Ongoing consultations with UNFPA and UNICEF, other H8 agencies, and with other key partners, will be bolstered post board. This will concentrate more on the 'how', including technical support issues.

**ANNEX 1****A summary of the HSS evaluation, tracking study, lessons learnt and IRC consultant review**

This is a summary of four pieces of work that will extensively guide further work on the design of GAVI HSS:

- Mid-term evaluation of GAVI HSS
- Tracking study
- Lessons learnt by the HSS task team
- IRC consultant review of possible GAVI Alliance minimum criteria for the joint assessment and common monitoring processes

Detailed results of all four pieces of work are available upon request and will be made available on the GAVI Alliance website.

**1. GAVI HSS mid-term 2009 evaluation**

**1.1 Background:** The original 2005 GAVI HSS investment case made provision for two evaluations:

- 2009; mid-term to take stock of what has been accomplished and learn lessons from the first two years of implementation; and
- 2012; focusing on assessment of the impact of health systems strengthening activities funded by GAVI on immunization coverage (and other health goals).

HLSP Ltd. won the RFP bid for the mid-term evaluation in February 2009, the period being evaluated is December 2005 – December 2008 and the evaluation aims to answer five questions:

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

The methodology includes five main components;

- i) Five<sup>23</sup> in-depth case studies with country visits: using desk reviews and in-depth national and sub national stakeholder analysis;
- ii) In-depth desk reviews of ten<sup>24</sup> country case studies;
- iii) GAVI HSS database will be used for storing information on the countries and processes reviewed;
- iv) HSS support systems: interviews and surveys to key stakeholders;

<sup>23</sup> Liberia, Cambodia, Rwanda, Pakistan, Burundi

<sup>24</sup> Georgia, Yemen, Kenya, Bhutan, Ghana, Honduras, Nicaragua, Sri Lanka, Nigeria, Sierra Leone

**ANNEX 1**

- v) 2012 evaluation will be guided by a ToR that will be drafted using the results for the 2009 evaluation.

**1.2 Key findings:**

The GAVI Alliance's decision to tackle health systems barriers was a good one, especially given that it was taken at a time when no other global initiatives were making similar support available to countries. Much of the support that was available at that time was heavily earmarked and burdensome to use. In contrast, GAVI HSS is based on country priorities and is flexible and easy to use. The objectives of GAVI HSS remain entirely valid and, with the prospect of expanding routine immunisation in low coverage areas, of the impending introduction of important new vaccines, and of the rapidly growing global support for more substantial and more coordinated health systems support to countries, GAVI HSS has a potentially important role to play. The evaluation therefore focuses more on details of the process.

The evaluation identifies a number of strengths and weaknesses:

*Identified strengths*

- The GAVI HSS window quickly attracted the interest of many low-income countries because it provides access to flexible and predictable funding for priorities they identify and through a fairly straightforward application process.
- HSS programmes have been very much country-driven, and most are quite well aligned with national policies and sector strategies. The flexibility of the GAVI HSS approach has enabled countries to design programmes around what they see as their real needs.
- GAVI HSS has helped focus attention on—and strengthen—governance, coordination mechanisms, planning, budgeting and financial management systems.
- The process of designing HSS proposals is non-prescriptive, simple and straightforward.
- Most countries have selected to implement 'downstream' activities in delivery of immunisation and maternal and child health services, rather than 'upstream' in sector-wide change or reform. These downstream interventions are likely to improve the quality and quantity of services delivered.
- Most countries have been "inclusive" in the design process by involving different ministries and their technical and development partners.

*Identified weaknesses*

- The relevance and quality of HSS technical support that partners provide to countries is variable. This support is concentrated on proposal design, and is insufficient or weak for start up, implementation and monitoring. Neither the financial nor the programmatic risks are being controlled adequately through the partnership model.
- In some countries not much was known about how HSS funds are being used, and this affects GAVI's ability to assess and manage risk effectively.
- The alignment with government monitoring and reporting systems has been weak.

## ANNEX 1

- The lack of adequate monitoring and the willingness to be very flexible means that the approach has been high risk with little guarantee that results can be demonstrated even where they occur.
- Some benefits gained from HSS may not be sustained following conclusion of the programme.
- Given the innovative nature of the HSS scheme and its considerable size, GAVI could be doing more to learn about it. It currently has limited institutional knowledge of the details of country HSS situations and the fast changing environments in which HSS investments are being made.

### Case study findings:

GAVI HSS support has resulted in a country led, flexible and reasonably predictable support for HSS for immunisation and child and maternal services, that would not have happened or would have happened more slowly without GAVI HSS. It may also have resulted in greater support for HSS than would otherwise have been the case, given that funding from alternative sources is likely to have been applied more vertically and thus resulted in further undermining of sector systems and processes, or might never have materialised and would have been lost to the sector. GAVI HSS has been keen to follow Government priorities but its alignment and harmonisation with government planning, monitoring and reporting systems has been weak, although stronger in countries with a SWAp.

- Countries have identified some of their real constraints on expanding services coverage, and have selected sensible objectives in reducing those constraints
- programmes have been very much country driven, and most are quite well aligned with national policies and sector strategies (if not so much with country processes)
- the flexibility of the GAVI HSS approach has enabled countries to design programmes around what they see as their real needs, not constraining them to preconceived problems or solutions
- countries are beginning to achieve results in terms of getting programmes underway, although some have had slow starts, and activities are consistent with those specified in the approved grant applications.

### Interventions:

- Mainly aimed at downstream MCH / immunisation delivery training, strengthening management and supervision and procuring supplies and equipment and improving their management, and many include improvements to information collection, rather than upstream sector wide reform. service delivery level interventions are more manageable, reflect the predominant role of EPI departments in programme design, and are the emphasis of GAVI HSS guidelines and intentions, whilst more systemic change must be more politically driven and requires substantial investment. Broadly consistent with 'Reach every district' strategy.

### Fund flow:

## ANNEX 1

- Programme start up has been slow in many countries due to delay in fund transfer and operationalising the handling of GAVI HSS funds. This requires greater clarity on timing of disbursements and stronger implementation plans
- Countries are able to show financial transfers or disbursements made to spending units (facilities, districts, institutions). However few can provide any evidence that the GAVI HSS funds have actually been used for the agreed activities. It is hoped that the provision of audits will remedy this
- Providing evidence for attribution (ie. funds \$ for \$ have been spent on allocated activities) is difficult
- GAVI should consider aligning fund disbursement with budget cycles

### Risk management:

- GAVI is not currently managing its risk profile well and some countries are regarded as high risk. This may have resulted from a mixture of design issues and technical support to ensure ongoing monitoring and evaluation processes are put into practice.

### Monitoring and knowledge management:

- One of the difficulties has been to track specific indicators due to lack of robust data management. This was especially so for linking proposed activities with outputs and a general difficulty in the context of overall weak systems in country to monitor these.
- It is suggested that constructive engagement with countries starts as soon as possible to ensure that data accuracy and reporting are incorporated in national systems and strengthened in the context of broad HMIS frameworks.
- Despite being country driven, there remains a weakness in linking constraints with proposed activities with outcomes. This stems from weak planning capacities and technical support for countries
- GAVI needs to strengthen its institutional knowledge and memory of details at country and it is suggested capacity needs to be increased to do so in a routine manner, not just from IRC processes.
- The APR process for HSS is questionable and needs review. This could be replaced by an in-country review with annual health sector reviews

### Technical support

- The current 'stand back and then review' process encouraged by the GAVI secretariat could be strengthened by adopting an 'engage and help' philosophy.
- The GAVI secretariat should consider increasing its own capacity to manage HSS
- A smaller HSS advisory group could replace the existing GAVI HSS task team to ensure continued advice is given to steer implementation and monitoring

*Postscript to the evaluation:* Since the evaluation was commissioned, the landscape has changed again. These findings are very timely, and will help to inform the future of HSS in a very positive way. The work on the common platform has opened up opportunities, and already allowed GAVI to begin addressing some of the weaknesses identified in the evaluation. We have already, through the Transparency and Accountability process, started tightening up considerably on financial management and risk assessment. Several Financial Management assessments have already been

## ANNEX 1

conducted. Subject to Board approval, the move towards more harmonised and aligned approaches opens up a new way of working. We will participate with other partners in joint reviews and in processes to develop robust output and outcome indicators, to make HSS more firmly performance-based, and to review the issue of technical support for implementation. Doing this in partnership with GFATM and the World Bank, and with WHO support, allows for greater efficiencies and the ability to draw on the comparative strengths of others, particularly those with country networks.

### 2. GAVI HSS tracking study

**2.1 Background:** Discussions during the February 2008 board meeting, HSS task team and the secretariat highlighted the need to provide ‘real time’, prospective detailed information on how countries were planning and implementing their HSS proposals (from programmatic and financial points of view). The RFP was jointly awarded to JSI (Inc) and In-Develop-IPM in June 2008 for the period June 2008 – October 2009. The purpose of the tracking study was to ensure there is enough information from country level in real time to guide the direction of GAVI HSS investment. The tracking study had three objectives:

1. To improve the quality of HSS project design/applications and strengthen implementation;
2. To develop responsibility and ownership over monitoring of GAVI HSS and its integration into ongoing processes at country-level through capacity building;
3. To establish a network of countries implementing HSS, beginning with the countries in the case studies, to facilitate cross-country learning and capacity building.

The methodology focused on implementation of activities and progress towards results using country-selected indicators six countries<sup>25</sup> that may not have been available in annual progress reports or in the evaluation. Six country research teams were constituted, comprised of national institutions, organizations or universities with expertise in health systems research.

**2.2 Key findings:** The gaps in implementation flow observed by the study team are not specific to GAVI HSS funding, rather they pertain more broadly to the implementation of the national health sector strategy and HSS efforts in general.

In assessing GAVI HSS implementation, a set of factors and themes were identified which define the context for implementation and may serve to either drive or hinder performance. Those factors and key findings include:

#### Planning, management and coordination

- Within the Tracking Study countries, responsibility for the management of the HSS-funded activities varies in regard to its institutional placement, reliance on existing government structures and human resources assigned. To date, these differing management arrangements appear adequately tailored to meet the needs of HSS implementation with one clear exception, the Democratic Republic of Congo.

---

<sup>25</sup> Democratic Republic of Congo, Ethiopia, Kyrgyzstan, Nepal, Vietnam, and Zambia

## ANNEX 1

### Financial flows

- As with the management arrangements above, countries chose a number of differing financial mechanisms to channel the GAVI HSS funds into the country. However, unlike the management arrangements – which appear adequately tailored to grant and country setting—the financial mechanisms can impact implementation.
- Most countries consider their GAVI HSS funds to be “on-budget,” although a variety of pooled and special account mechanisms are being used.
- Several countries with pooled funding mechanisms chose to manage their GAVI HSS funds in accordance with the SWAp mechanism and not to channel the HSS funds through a separate and non-pooled account. Countries cite the need to link and report on their HSS support for specific types of activities and results as the primary barrier to including these funds in pooled funding mechanisms.
- In at least three of the countries, two-thirds or more ( $\geq 67\%$ ) of HSS funds are used for central-level procurement of goods and services, which are used and or delivered at the sub-national level.
- Several countries have relied on development partners with well-established mechanisms and procedures to “jump start” large-scale procurement of goods and services. The challenge in this situation is striking a balance between efficiency of implementation and building the capacity of national institutions.

### HSS monitoring and evaluation

- There is insufficient attention to collecting and analyzing output-level measures—which reflect tangible changes in service availability, accessibility and quality that result from the types of investments made with GAVI HSS funding (i.e., human resources for health; supplies, equipment and infrastructure; and management and organization). This gap results in an inability to fully describe the sequence of activities, interim (outputs) and longer-term results (outcomes/impacts) as was intended in the HSS framework.

### Technical support

- In general, the Tracking Study countries rely on longer term, locally available sources of technical support rather than acquiring short-term external assistance. The role of CSOs and NGOs to support implementation can be juxtaposed with HSS proposal development processes, where little direct involvement of these groups was reported.

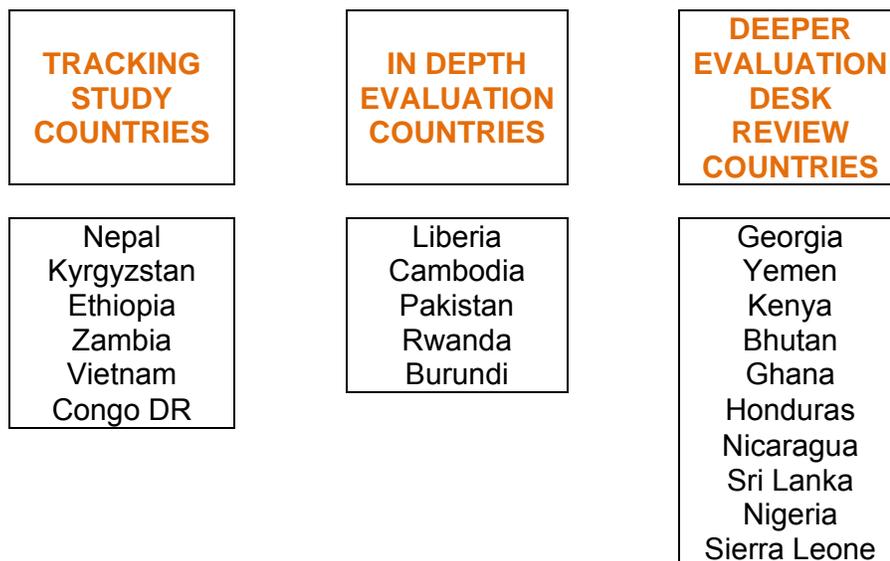
The Tracking Study’s conclusions and recommendations are based upon information gathered through primary data collection in the six Tracking Study countries. Recommendations were discussed and adjusted by the Tracking Study team and participants of the six countries, including local research teams and government officials, during a three-day Multi-Country Workshop held in Stockholm, 15-17 September 2009.

### **3. Synergies between evaluation and tracking study**

The GAVI HSS Tracking Study provides in-depth detailed data and information on implementation from sub national level, collected prospectively which will complement

## ANNEX 1

the evaluation analysis. The evaluation and tracking study together complement one another to make recommendations on the design and implementation issues related to GAVI HSS. The GAVI Secretariat has helped facilitate sharing and discussion of preliminary findings and reports between the two teams and together the two pieces of work will cover all countries at least from a proposal review point of view and in depth analysis of 21 countries, outlined below.



<b>Evaluation or tracking study</b>	<b><u>What the study is focusing on</u></b>
<b>Evaluation</b>	<b><u>Global, regional and country levels</u></b> Quality of inputs from partners Value added of HSS against other source of funding for systems Coordination and support mechanisms at global, regional and country level
<b>Both</b>	<b><u>Country level</u></b> Application process, Implementation, Monitoring
<b>Tracking study</b>	<b><u>National and sub national levels</u></b> In-depth monitoring Developing more country ownership How to integrate GAVI HSS monitoring processes into existing M+E frameworks Establish and strengthen network capacity for tracking HSS

#### 4. HSS task team lessons learnt:

The multi partner HSS task team has helped guide the design and implementation processes of GAVI HSS since April 2006 and has also acted as a conduit for information dissemination and reception. This group has been co chaired by WHO,

## ANNEX 1

UNICEF and World Bank and includes representatives from DFID, USAID, NORAD, developing countries, civil society, Bill and Melinda gates Foundation as well as the GAVI secretariat. The group drafted a paper that gave guidance to any future guiding body for GAVI HSS and many of their observations echo and replicate those of the evaluation and tracking study.

### ***Application process***

- Overall concept of analysis of health systems constraints makes sense.
- One rigid application process will not suit all countries – need 2-3 different models.
- A globally-centralized IRC-type model cannot tap into the local knowledge which is crucial to assess HSS applications and cannot respond to country needs in terms of the timing of decisions.
- The IHP+ model, though still new, offers potential.
- Ensure documentation available in all relevant languages and application rules work for all types of country (including small states).

*Recommendation:* Whatever the selected scheme, a good analysis of country health needs and country health system constraints is required. In all cases, it is essential to assess situation at country level, to utilize the country's official language, and to base GAVI support on country national planning and budgeting cycles.

### ***Monitoring***

- Links between HSS activities and immunization coverage take time to work through and require a hierarchy of well thought-out indicators. Most countries fall far short of this.
- Country reporting in the HSS section of the APR is sometimes scant
- The APRs do not provide the Monitoring IRC with enough information to be able to assess if implementation is progressing satisfactorily – disbursements are not performance-based.
- Whatever the future of GAVI HSS, a great deal of money has already been “awarded” and disbursed (respectively \$m 524 and 261) – monitoring of these grants needs to be strengthened.

An over-riding priority is to establish what constitutes “satisfactory monitoring” and how this can be achieved in a variety of country contexts.

*Recommendation:* In case of the IHP+ scheme, monitoring is in principle done through National Planning Cycle mechanisms (M&E system and annual/regular reviews processes). In case of applications, attention should be paid to ensure that indicators really allow for monitoring links between HSS and immunization coverage, and for monitoring performance.

### ***Governance***

## ANNEX 1

- Current model of reliance on in-country partners means that GAVI HSS is vulnerable to issues not being dealt with at country level and/or not communicated to regional and global levels. The role of partners (especially in supporting implementation) needs to be clarified –but not in terms of a one-size fit all model.
- Regional Working Groups could be strengthened to have a stronger role in GAVI HSS.

*Recommendation:* GAVI relies on in-country partners regarding highlighting/dealing with possible in-country problems. There needs to be clarity about the role of partners and improved “ownership” of GAVI HSS amongst in-country partners to ensure that important issues are tackled in country.

### **Harmonization and alignment**

- To achieve H&A, the business model needs to be able to tap into understanding of country contexts and to respond to national planning cycles.

### **Technical support**

- Need to have a mechanism for provision of technical support at all stages of the HSS cycle: many countries have not budgeted adequately for this in their proposals.
- Continue with sub-regional peer meetings.

*Recommendation:* Countries do not always budget adequately for technical support. There needs to be a simple arrangement for countries to access technical support as and when they need it.

### **Other implementation issues**

- The Financial Management Assessments are likely to lead to further delays in disbursement/ implementation and worsening record of H&A/predictability. In future this should be done before an application is finalized.
- Principles for procurement need to be stipulated.
- Improved tracking of applications (budget requests, conditions met, etc) to ensure readiness for implementation.

### **Overall portfolio**

- Build in a learning approach from the start – e.g. with “pathfinder” countries
- The reports of the HSS Evaluation and the HSS Tracking Study are key documents due out by October 2009 and should be studied with care.

### **5. IRC consultants review of minimum criteria:**

The GAVI secretariat asked 6 Independent Review Committee members to undertake 4 tasks as part of a desk review:

- a) Suggest minimum criteria necessary for the GAVI Alliance to make initial funding decisions based on using the IHP+ Joint Assessment Tool (JANS v 4);

**ANNEX 1**

- b) Suggest minimum monitoring indicators and processes required for the GAVI Alliance to monitor systems investments, using the IHP+ common monitoring framework;
- c) Identify key challenges of such an approach for GAVI; and
- d) Suggest any changes to the JANS v 4 tool that may strengthen its use if the GAVI Alliance were to use it to make funding decisions.

**Process:** 6 IRC reviewers applied the JANS v 4 tool and common monitoring framework to 26 countries national health plans as a desk review, whilst also holding true to the current GAVI mission, principles and policies. This helped identify the minimum criteria, suggested modifications to the JANS tool and some minimum monitoring criteria. An **adapted** JANS tool was then applied to 26 country documents and an assessment made of the key issues likely to surface in the possible event of GAVI using such an approach in the context of a joint funding platform.

**Key findings:** It was felt that the current version of the IHP+ JANS tool (v 4) can certainly be used for national health plans and strategies as a funding decision making tool by the GAVI Alliance. In fact the tool asks for much more information than is currently required by GAVI for its HSS window. The vast majority of necessary attributes are already reassuringly incorporated within the tool. However, after reviewing the 26 country documents, the consultants suggest some minor modifications to the tool, with some suggested rewording and reordering to increase clarity. The suggested changes (for the adapted tool) are currently being considered by the IHP+ core team and some adaptations may need to be made before GAVI could use it as a tool on which to base funding decisions.

In addition to the suggested changes to the tool, it is important (essential) that the following are available within National Health Plans (that may not be specifically part of the tool):

<b>For funding decisions</b>	<b>For monitoring</b>
Population, GNI per capita, Percentage of GNI allocated to health, Percentage of government expenditure on health, Annual birth cohort, Surviving infants, Infant mortality rate, Under five mortality rate, National DTP3 coverage rate and % districts achieving >80% DTP3 coverage	Under five mortality rate (per 1000), National DTP3 coverage (%), Number / % of districts achieving ≥ 80% DTP3 coverage, Three additional impact/outcome indicators, Up to 6 output indicators, Appropriate progress indicators that could be monitored during the annual progress reviews

*Key gaps in documentation sent to GAVI as part of HSS proposals that may not be addressed by applying the JANS tool:* After all 26 country documents and plans were reviewed using the suggested adapted JANS tool a summary was made of how many countries could 'satisfy' the criteria outlined in the tool. This was provided in detail and some parts where the country plans may not address requirements in the JANS tool include:

- Procurement and legislative frameworks and regulating these
- Budget and fiscal space estimates for scaling up based on sound economic analysis

## ANNEX 1

- Financing and auditing procedures in general (this may be a reflection of the intensive work on the JANS tool from other partners who may need stringent budgeting and audit requirements. It should be noted that much of what is asked in the JANS tool in this section may not have been asked for previously)
- Aspects of the of M+E framework

*Essential / desirable / not required attributes:* The JANS tool was applied to 26 country health plans and other documents sent to GAVI as part of HSS proposals. Whilst taking into consideration the GAVI mission, current policies, principles of support and guidelines the team made a synthesis of the JANS tool and made some recommendations of what elements of the *adapted* JANS tool may be essential, desirable or not necessary for the GAVI Alliance, if the Alliance were to use the JANS tool on which to base funding decisions.

*Country specific analyses:* All 26 country specific analyses using the revised JANS tool are available on request. The available documentation varies from country to country. These highlight country specific information / issues that may need to be adapted or considered in depth (at a later date) if GAVI were to make a funding decision based on the JANS tool.

**ANNEX 1**

4 groups of countries need to be considered in the table below:

Never applied for GAVI HSS (9/72)	Applied previously but without approval (14/72)	Current GAVI eligible countries that are in the World Bank/HLTF Low Income Country (LIC) classification (49/72)	Current GAVI eligible countries that are NOT in the World Bank/ HLTF Low Income Country (LIC) classification (23/72)
<ul style="list-style-type: none"> <li>• Angola</li> <li>• Guyana</li> <li>• Haiti</li> <li>• Kiribati</li> <li>• PNG</li> <li>• Sao Tome &amp; Principe</li> <li>• Timor Leste</li> <li>• Ukraine</li> <li>• Uzbekistan</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Benin*</b></li> <li>• Comoros</li> <li>• Congo</li> <li>• Djibouti</li> <li>• <b>Gambia*</b></li> <li>• <b>Guinea*</b></li> <li>• India</li> <li>• <b>Laos*</b></li> <li>• <b>Mauritania*</b></li> <li>• Mozambique</li> <li>• <b>Niger*</b></li> <li>• <b>Somalia*</b></li> <li>• Tanzania</li> <li>• <b>Togo*</b></li> </ul> <p><b>*Countries from the last IRC Round (Oct) that will be under future consideration by the Board</b></p>	<ul style="list-style-type: none"> <li>• Afghanistan</li> <li>• Bangladesh</li> <li>• Benin</li> <li>• Burkina Faso</li> <li>• Burundi</li> <li>• Cambodia</li> <li>• Central African Republic</li> <li>• Comoros</li> <li>• Core d'Ivoire</li> <li>• DRC</li> <li>• Eritrea</li> <li>• Ethiopia</li> <li>• Gambia</li> <li>• Ghana</li> <li>• Guinea</li> <li>• Guinea Bissau</li> <li>• Haiti</li> <li>• Kenya</li> <li>• Korea DPR</li> <li>• Kyrgyzstan</li> <li>• Lao</li> <li>• Liberia</li> <li>• Madagascar</li> <li>• Malawi</li> <li>• Mali</li> <li>• Mauritania</li> <li>• Mozambique</li> <li>• Myanmar</li> <li>• Nepal</li> <li>• Niger</li> <li>• Nigeria</li> <li>• Pakistan</li> <li>• Papua New Guinea</li> <li>• Rwanda</li> <li>• Sao Tome Principe</li> <li>• Senegal</li> <li>• Sierra Leone</li> <li>• Solomon Islands</li> <li>• Somalia</li> <li>• Tajikistan</li> <li>• Tanzania</li> <li>• Tchad</li> <li>• Togo</li> <li>• Uganda</li> <li>• Uzbekistan</li> <li>• Vietnam</li> <li>• Yemen</li> <li>• Zambia</li> <li>• Zimbabwe</li> </ul>	<ul style="list-style-type: none"> <li>• Angola (Never applied)</li> <li>• Armenia (Predicted to apply for continuity of funding in '11)</li> <li>• Azerbaijan</li> <li>• Bhutan</li> <li>• Bolivia (Predicted to apply for continuity of funding in '11)</li> <li>• Cameroun</li> <li>• Congo</li> <li>• Cuba</li> <li>• Djibouti</li> <li>• Georgia (Predicted to apply for continuity of funding in '11)</li> <li>• Guyana</li> <li>• Honduras (Never applied)</li> <li>• India (Applied previously but without approval)</li> <li>• Indonesia (Predicted to apply for continuity of funding in '11)</li> <li>• Kiribati (Never applied)</li> <li>• Lesotho</li> <li>• Moldova</li> <li>• Mongolia</li> <li>• Nicaragua</li> <li>• Sri Lanka</li> <li>• Sudan (North and South)</li> <li>• Timor Leste</li> <li>• Ukraine</li> </ul>