

Proposal for GAVI to Invest in Health Systems Strengthening (HSS) Support

10 November 2005

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EXECUTIVE SUMMARY

This document describes the proposed Health Systems Strengthening (HSS) investment, which has the **objective**:

To achieve and sustain increased immunization coverage in all GAVI eligible countries, through strengthening the capacity of the health system to provide immunization and other health services.

Amongst other benefits, this will contribute to the reduction in child and maternal mortality in line with the Millennium Development Goals.

Problem identification and proposal development

In 2004, the GAVI workplan included a study of System Wide Barriers to increased immunization coverage. This study concluded that all the countries visited had health systems issues which constrained immunization coverage – but the particular issues were different in each country. Constraints included unpredictable funding at the service delivery level; lack of transport; shortages of human resources; and problems with health worker motivation. These findings led to the development of this HSS proposal.

This proposal has been developed in close co-operation with the HSS Reference Group. A number of issues and alternatives were discussed within the Group – Section 7 of this proposal describes the main issues raised and strategies identified to minimise the risks of HSS.

Key features of HSS

HSS is based on the idea that immunization coverage is often constrained by health systems issues that are not immunization-specific. HSS invites countries to describe specific activities that will overcome one or more of these constraints.

The importance of **themes** within HSS was stressed by the GAVI Board in July 2005. GAVI cannot fund all aspects of health systems strengthening and needs to keep a clear focus on the areas where it can provide the most added value. The idea is that the themes provide guidance to countries about health systems strengthening activities that are likely to meet the requirements of HSS and improve immunization coverage.

The HSS themes are the health workforce, supply logistics and local management – these were developed from a WHO analysis of key health system components. Because they are crucial to the delivery of immunization services, it is expected that most activities will fall within the HSS themes – however well-justified applications in other areas will be welcomed and will have an equal chance of approval.

GAVI is committed to **working closely with other Global Health Partnerships**. In particular, immunization and maternal/child health services are inextricably linked. A broader health systems perspective allows GAVI to work in synergy with others, including the new Partnership for Maternal, Newborn and Child Health, to tackle many of the shared barriers to achieving better health.

In general, HSS has been designed following the Best Practice Principles on **harmonization and alignment** for Global Health Partnerships which have recently been developed for the High Level Forum on the Health MDGs.

The **application process** is based on two principles:

- All proposals must include an analysis of the problem; a planned solution, with implementation details; and a description of how progress and the impact on immunization coverage will be monitored.
- Whilst a minimum set of information is obviously required, the application process should not involve a duplication of work that has already been done. Existing documents (such as national health plans or Immunization Multi-Year Plans) will be accepted, provided that applicants clearly demonstrate how these are relevant to the proposal.

HSS will be **performance-related** in two main ways:

- If a country is not achieving its process indicator targets, GAVI will reduce the funds released and implement a diagnostic review. A technical team will review and analyse the country approach and help the country to improve its performance. This mechanism will start after the second year of support to a country.
- If progress is unsatisfactory by the next year, GAVI will consider stopping funds.

There is a strong emphasis in all HSS processes on monitoring performance - countries have to justify and later demonstrate the link between their proposed activities and immunization coverage. This is stressed in the application process, the review of applications and in the monitoring framework.

HSS will be offered to all GAVI-eligible countries. The way HSS is set up, however, means that it is best suited to countries with the capacity to develop and implement credible, costed plans to strengthen district health services, including immunization. It is thus recommended that the GAVI Board consider developing a new mechanism for persistently **poor immunization performers**, especially the countries with large un-immunized populations that are of particular importance to achieving GAVI's global milestones.

The active involvement of many **partners** is necessary for HSS to be successful. Key points to note are enhanced roles for the Ministry of Health Planning Department and the Ministry of Finance; and the new role of HSS country facilitator.

In the first year of HSS, a number of **pathfinder countries** will work closely with the Launch Team – these countries will be the first HSS applicants. This approach will allow tools to be tested; lessons to be learnt about the types of support likely to be requested; and estimates to be made of the resources required to submit an application. The pathfinder countries can then play a role in supporting others in the region.

The Board is asked to consider two options related to pathfinder countries. The second option is a more actively-managed approach than the first.

- Pathfinder countries can volunteer themselves because they are interested in applying for HSS at an early stage.
- The number of pathfinder countries should be identified in advance – 10, for example. The Secretariat should be actively involved in the selection of these countries.

Budget and management of HSS

The available budget for HSS is estimated at \$800 million for five years, allocated to countries according to the size of their birth cohort, with an additional weighting for countries with less than \$365 GNI per capita. \$16 million (2%) is set aside for management and technical support.

If 10 pathfinder countries are identified in advance by GAVI, and supported in the first phase of HSS (2006-2010), approximately \$300 million will be required (including 2% for management and technical support and the evaluation in 2009).

If countries are interested in applying for HSS at an early stage, and volunteer themselves to be a pathfinder country, then there are no limits on the numbers of countries, and up to about \$573 million should be allocated (including 2% for support as above)¹.

A Launch Team and HSS Steering Group will support the GAVI Secretariat in its expanded management role to support HSS.

The performance of HSS as a whole will be thoroughly assessed. Independent evaluations will be commissioned in January 2009 and in 2012. The preliminary evaluation will allow lessons to be learnt from the early implementation stages. This in effect reduces the riskiness of HSS – if necessary, substantial changes can be made in year 4.

GAVI reserves the right to ask for a financial audit at any time, so that fiduciary concerns can be addressed promptly.

¹ It has been estimated in this second case that approximately a third of countries would apply for HSS in 2006 (and receive 4 years support), another third will apply in 2007, and another third in 2008. All countries will be eligible for support until the end of 2010.

Proposal for GAVI to Invest in Health Systems Strengthening (HSS) Support

Section 1 Introduction

This document describes the proposed Health Systems Strengthening (HSS) investment, which has the objective:

To achieve and sustain increased immunization coverage in all GAVI eligible countries, through strengthening the capacity of the health system to provide immunization and other health services.

Amongst other benefits, this will contribute to the reduction in child and maternal mortality in line with the Millennium Development Goals.

The document is in 7 sections. Following this introduction, Section 2 identifies the problem which HSS is designed to tackle and describes the steps leading up to this proposal. Section 3 provides an overall description of HSS; Section 4 describes how HSS will be monitored. Section 5 looks at the costs and global management of HSS; Section 6 looks at HSS in the wider context of GAVI and its other windows. Finally, Section 7 describes the risks of the investment and recounts some of the issues and challenges encountered in developing this proposal.

The term “health systems strengthening” can be interpreted in many ways. This proposal follows the WHO terminology developed by Evans² – see Box 1.

² WHO, 2005. (Tim Evans) ‘Health System Action Agenda and the Role of Global Health Initiatives’. *Draft*. Order of components has been changed from the original.

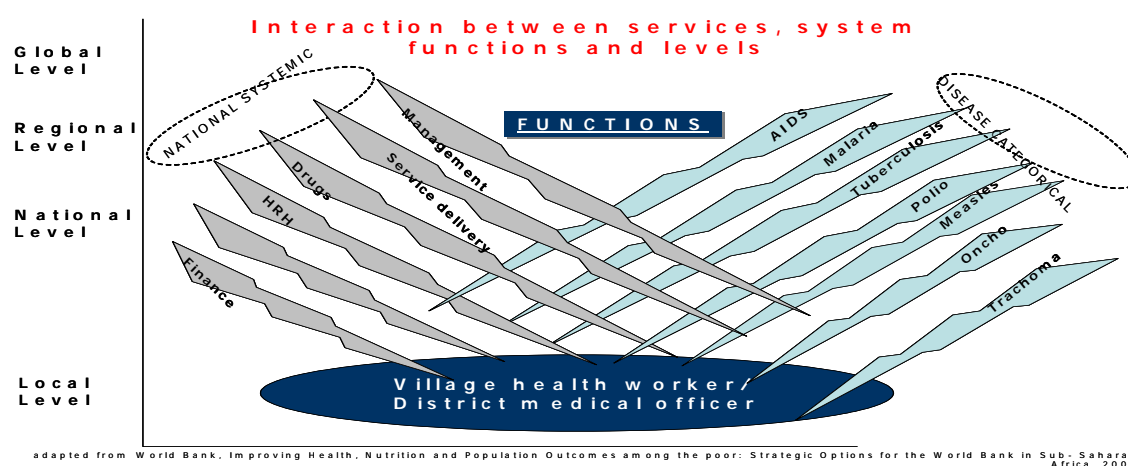
Box 1 What is health systems strengthening?

“Health systems strengthening is defined here as getting some critical health system components into 'good working order':

- health workforce mobilization, distribution, and motivation
- drugs, equipment and infrastructure supply, distribution, maintenance
- the organization and management of health services
- leadership and stewardship
- the health financing system (collection, pooling, purchasing)
- national information and monitoring systems

in ways that allow **more**, more **equitable** and **sustained improvements** in service outputs and outcomes.

Building capacities in these areas may, depending on the causes of the problems identified, involve actions at **one or more levels**, from household up to national and even global level. It may involve changes in skills and knowledge; in key support systems, or in structures and policies. It will almost always involve many different actors.”



Section 2 From Problem Identification to HSS Proposal

Right from the start of Phase 1, GAVI has recognised the importance of *systems* – hence Immunization Services Support (ISS) funding. ISS was made available to countries to spend as they saw fit – this could be for wider health systems activities and/or immunization program needs. In practice, the way ISS is managed (involving the EPI Manager and the Inter-Agency Coordinating Committee, ICC) means that it has generally been used for immunization program expenditures.

Towards the end of Phase 1, GAVI partners began to recognize that continuing investment in ISS might be necessary but not sufficient to maintain and extend immunization coverage gains in many countries. The 2004 GAVI workplan thus included work on exploring the system barriers to increasing and sustaining immunization coverage.

A methodology for the rapid assessment of health system barriers to immunization was developed and used in eight countries.³ This *System Wide Barriers* work found that all the countries faced wider health systems constraints to increased coverage, but that the specifics varied greatly from country to country. Some of the most important constraints identified were unpredictable funding at the service delivery level; lack of transport, including for outreach activities; shortages of human resources at all levels; and problems with health worker motivation. It was concluded that in order to sustain and increase coverage there is a need to address these system barriers.

At the same time as the thinking on health systems strengthening was developing, GAVI committed itself to working closely with other Global Health Partnerships. In practice, this means that immunization cannot be seen in isolation from other health activities – GAVI should actively seek out areas for collaboration and co-ordination. In particular, immunization and maternal/child health services are inextricably linked – the services tend to be delivered by the same health workers; mothers and children are key target groups for immunization; and immunization is a key strategy for improved maternal and child health. A broader health systems perspective allows GAVI to work in synergy with others, including the new Partnership for Maternal, Newborn and Child Health to tackle many of the shared barriers to achieving better health.

To improve and sustain immunization coverage also requires capacity to deliver and sustain the other frontline health services. This proposal thus recommends an investment that will strengthen countries' capacity to deliver immunization and other health services.

This thinking is in line with the Millennium Development Goals, which does not have a specific immunization goal. Instead immunization is an integral part of all the health goals.

This proposal has been developed in close co-operation with the HSS Reference Group, whose members have participated in a number of tele-conferences and a meeting in Geneva in October 2005. The invaluable contribution of this Reference Group is gratefully acknowledged.

³ GAVI: Alleviating System Wide Barriers to Immunization, 2004

Section 3 Description of HSS

PROJECT SUMMARY

Objective

To achieve and sustain increased immunization coverage in all GAVI eligible countries, through strengthening the capacity of the health system to provide immunization and other health services.

Description

HSS is based on the idea that immunization coverage is often constrained by health systems issues that are not immunization-specific. HSS invites countries to describe specific activities that will overcome one or more of these constraints. An emphasis on performance indicators and a rigorous application review process will ensure that the proposed activities will improve immunization services.

It is expected that many of the HSS activities will be consistent with the HSS themes of the health workforce, supply logistics and local management. Countries are, however, free to justify activities in other areas.

The budget for HSS is estimated at \$800 million for five years and will be available to all GAVI-eligible countries, allocated to countries according to the size of their birth cohort, with an additional weighting for countries with less than \$365 GNI per capita. \$16 million (2%) is set aside for management and technical support.

3.1 Conceptual Framework

HSS is based on the idea that immunization coverage is often constrained by health system issues that are not immunization-specific. Examples are:

- unmotivated field staff, overworked and not receiving feedback or encouragement from their managers
- weak logistics in remote districts, so that clinics are not receiving regular supplies of drugs, fuel, vaccines and syringes
- funds are not released regularly to districts and health facilities, making it difficult to pay for basics such as fuel
- staff are untrained in the basic maintenance of equipment such as bicycles, sphygmomanometers and refrigerators, leading to unnecessary breakdowns.

HSS offers funding to overcome such constraints.

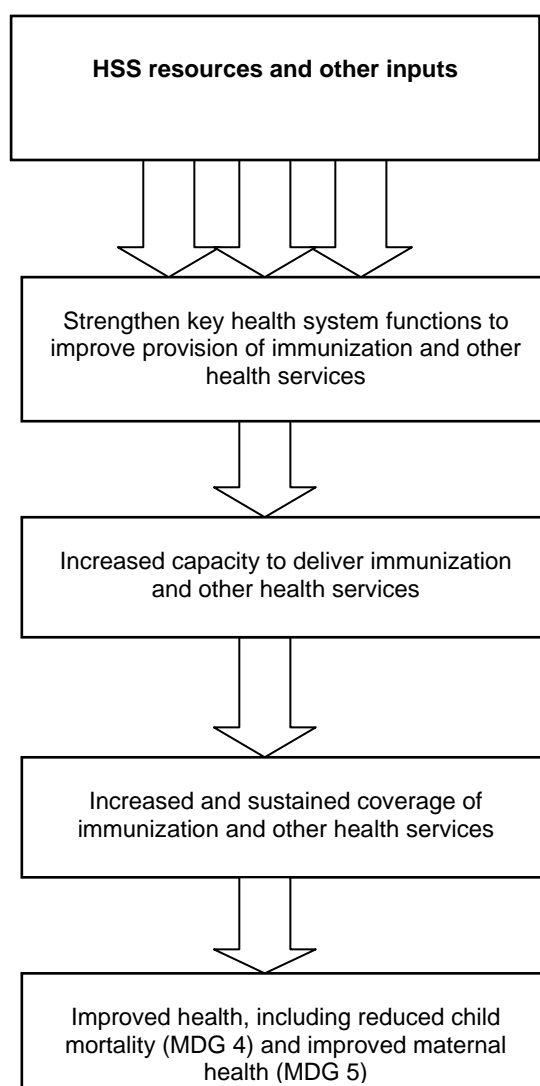
Figure 1 illustrates the thinking that underpins HSS.

The idea is that HSS funds are used to improve some aspect of the health system that is hindering increased immunization coverage. Because so many of a health system's resources are shared by several technical programs, this will improve not only immunization coverage but also other aspects of the health system.

Another way of looking at GAVI's involvement with health systems is in terms of a stone dropping into water. The point where the stone lands in the water is immunization coverage – the centre of GAVI's focus. Close ripples are other services delivered by frontline health workers; more distant ripples are technical and managerial support activities. All contribute to improving health status – GAVI focuses on immunization, but has a strong interest in what the other "ripples" achieve too.

A practical example of this framework is supervision of health post workers. A country may apply for funds to improve the quality and regularity of supervisory visits to health posts, the most local level of health facility. The country has evidence to show that immunization rates for individual health post workers gradually drop, the longer the time between supervisory visits. Of course the visits do not only deal with immunization – there may be some clinical cases to review and the worker may want help with personnel or logistic matters. There is a measurable impact on immunization, but also benefits to the primary health care system in general.

Figure 1. Framework for HSS



3.2 Themes

A crucial stage in the conceptual framework is identifying the content of the second box down – i.e. what are the appropriate health systems strengthening activities that will have a long-lasting impact on immunization services?

To ensure that appropriate activities for HSS support are identified, HSS offers support at this stage in 3 ways:

- through rigorous application and review processes
- an emphasis on monitoring and demonstrating a link between HSS-supported activities and immunization coverage

- guidance through the promotion of HSS themes.

The importance of themes within HSS was stressed by the GAVI Board in July 2005. The Board is aware that GAVI cannot fund all aspects of health systems strengthening and needs to keep a clear focus on the areas where GAVI can provide the most added value.

The idea is that the themes provide guidance to countries about health systems strengthening activities that are likely to meet the requirements of HSS and improve immunization coverage. At the same time, these are areas where GAVI will be able to offer particular expertise.

This emphasis on themes seems to have been vindicated by the recent experience of the Global Fund. The review of the first round of Global Fund HSS proposals concluded:

“The definition of HSS proposals in the Proposal Form and Guidelines was too vague and too broad, with little guidance to applicants on any specific focus for these proposals. The TRP {*Technical Review Panel*} believes that this was definitely a factor contributing to the large number of broad, vaguely specified and overambitious HSS proposals.”

By providing focus, the GAVI themes are a response to the concern of some GAVI partners that HSS funding will become 'lost' within the vast array of health systems strengthening activities and funders, with the central link to immunization being much diminished.

As was seen in Box 1, WHO has defined Health Systems Strengthening as “getting some critical health system components into ‘good working order’:

- health workforce mobilization, distribution, and motivation
- drugs, equipment and infrastructure supply, distribution, maintenance
- the organization and management of health services
- leadership and stewardship
- the health financing system (collection, pooling, purchasing)
- national information and monitoring systems”

Of these components, the first three are particularly relevant to the service delivery point and first supervisory level (often referred to as districts). Because immunization depends on providing services that are accessible to everyone, the HSS themes are based on these first three, localised components. Immunization services are actually provided at this level (usually primary health facilities and districts or equivalent), and rely on the human resources needed to plan and deliver these services.

The recommended themes for HSS support are therefore:

- 1) health workforce mobilization, distribution and motivation *targeted at those engaged in immunization and other health services at the district level and below*
- 2) drugs, equipment and infrastructure supply, distribution and maintenance *for primary health care*
- 3) the organization and management of health services *at the district level and below (including financing issues).*

Using these themes as a starting point, countries will be asked to identify the most important issues in the health system that they want to address with HSS support. Because they are crucial to the delivery of immunization services, it is expected that most activities will fall within the HSS themes – however well-justified applications in other areas will be welcomed and will have an equal chance of approval.

Whilst the themes point to the central importance of local service delivery, this does not imply that all HSS funding has to take place at the district level or below. Health systems tend to be structured in a hierarchy, climaxing in national leadership. Regional and national support functions – such as medical stores and health information - provide local services with vital resources. The message of the themes is that they are a good place to start the analysis of barriers to increased coverage and a good place to start identifying solutions. Proposals that trace the barriers to levels above the district may be perfectly valid.

3.3 Country Applications

The application process is based on two principles:

- All proposals must include an analysis of the problem; a planned solution, with implementation details; and a description of how progress and the impact on immunization coverage will be monitored.
- Whilst a minimum set of information is obviously required, the application process should not involve a duplication of work that has already been done. Existing documents (such as national health plans or Immunization Multi-Year Plans) will be accepted, provided that applicants clearly demonstrate how these are relevant to the proposal.

The application requirements are:

- National or local plans for strengthening services at the district level. Existing documentation, or countries to analyse district health system barriers and present a plan to address key constraints.⁴
- Details of the activities that GAVI will fund in the plans – and information about what government and other partners are funding.
- An explanation of why the activities are critical for increasing or sustaining immunization coverage and when coverage is expected to improve.
- A monitoring plan including indicators, targets, a timeline and baseline data, with an indication of how accurate data will be collected.
- Information on the proposed mechanisms for channelling and allocating funds, management, audit and accountability.

All HSS applications will need to meet the following criteria:

- Activities are critical for raising and/or sustaining immunization coverage.
- The level and nature of GAVI support will make a difference.
- The activities are integrated into national plans.
- Progress can be monitored.
- The proposal is endorsed by the Ministry of Finance and relevant in-country partners.

HSS will fit into existing country processes and planning cycles. For that reason, proposals will cover varying periods of time (usually from 3-5 years).

Where necessary, GAVI will make resources available to countries to help prepare the applications; undertake the analysis of health system capacity; and develop monitoring and implementation plans.

More information on the application process is provided in the *GAVI Guidelines on Country Proposals*.

⁴ Existing appraisal tools can be used for this analysis. The analysis will be the basis of an overall plan for strengthening capacity in key health system functions – HSS resources will then fit into this plan.

3.4 Responding to Performance

HSS will be performance-related in two main ways:

- If a country is not achieving its process indicator targets, GAVI will reduce the funds released and implement a diagnostic review. A technical team will review and analyse the country approach and help the country to improve its performance. This mechanism will start after the second year of support to a country.
- If progress is unsatisfactory by the next year, GAVI will consider stopping funds.

Monitoring is discussed in more detail in Section 4.

3.5 Strategies for Different Country Environments

As agreed at the July 2005 GAVI Board meeting, HSS will be offered to all GAVI-eligible countries. The way HSS is set up, however, means that it is best suited to countries with the capacity to develop and implement credible, costed plans to strengthen district health services, including immunization. Many GAVI-eligible countries are weak in this area – and these countries account for a significant proportion of the world's unimmunized children. Two particular categories of country have been identified which call for somewhat different approaches, particularly in terms of the application process, monitoring and the release of funds.

Countries with persistently low immunization coverage. Many countries with persistently low coverage have major underlying health system weaknesses. These may be so pervasive that the country finds it difficult to prepare a credible HSS application. Additional efforts will be required to support these countries, beyond financial support. It is thus recommended that the GAVI Board consider developing a new mechanism for persistently poor immunization performers, especially the large countries with large un-immunized populations that are of particular importance to achieving GAVI's global milestones.

Countries in conflict or fragile states (where there is no effective government for all or part of the country). For such countries, the funds can be released to an intermediary organization (e.g. UNICEF, an NGO)⁵. Many such countries will need a substantial technical input from GAVI and partners to prepare a credible application. It is likely that a greater degree of involvement of non-state providers will be required to deliver services.

3.6 The Roles of Partners

The active involvement of many partners and stakeholders is necessary for HSS to be successful. In the application process, countries will be asked to describe the key actors and their responsibilities. Possible roles for partners at a country level are listed below. Key points to note are enhanced roles for the Ministry of Health Planning Department and the Ministry of Finance; and the new role of HSS country facilitator.

Planning Department, Ministry of Health

- preparing the application
- overseeing implementation and monitoring
- liaising with stakeholders to ensure that HSS-funded activities conform with national plans and the principles of harmonization and alignment

Ministry of Finance

- endorsing the HSS application before submission to GAVI

⁵ The approach should be consistent with ongoing work by OECD/DAC on service delivery in fragile states, and by the High Level Forum on Health MDGs.

- overseeing the channelling of money from GAVI

Immunization Program Manager and ICC

- identifying the requirements of a successful immunization program, the system areas that most need to improve and ensuring links to the Multi-Year Plan
- supporting Ministry of Health colleagues in preparing the application and during implementation and monitoring

Bilateral and multilateral partners

- working with Ministry of Health to ensure that HSS support is directed towards the key health system constraints and respects the principles of harmonization and alignment
- providing information and technical support (if possible) to develop and implement HSS
- participating in joint monitoring activities
- endorsing the HSS application

HSS country facilitator (optional)

- an in-country development partner may be identified as the 'country facilitator'
- providing an additional in-country link for GAVI
- facilitating harmonization and alignment with country plans and processes (including the MYP) and the plans of other partners and global partnerships
- facilitating technical support to the Ministry of Health in developing the HSS application and its implementation
- taking a role in monitoring and review of progress, and in identifying need for an audit.

3.7 Harmonization and Alignment

A major challenge in the design of HSS is to ensure that GAVI support is consistent with international commitments to harmonization and alignment. 'Harmonization and Alignment' assumes development agency support that is co-ordinated, and aligned to government plans, priorities and procedures. The key partners funding GAVI have agreed on specific measures to promote harmonization and alignment in the Paris Declaration on Aid Effectiveness (March 2005). In addition, 'Best Practice Principles' on harmonization and alignment for Global Health Partnerships have recently been developed for the High Level Forum on the Health MDGs.⁶

HSS has been designed following these Best Practice Principles. Funds will be made available for activities identified by the countries themselves. Countries do not necessarily have to do a separate assessment for an HSS application – existing plans can be presented. These features of HSS should mean that it is aligned with country plans and co-ordinated with other inputs. Countries should feel a strong sense of ownership since they make their own plan for HSS, and can benefit from low transaction costs if their health planning system is of a reasonable quality.

There are many ways in which HSS support can be aligned with country processes. HSS can use: country planning cycles and fiscal calendar; mechanisms that suit the country best for channelling funds and procuring supplies or services (assuming that basic standards of probity are met); and country mechanisms for audit and accountability (again, subject to minimum standards).

The extent to which HSS will be harmonized will depend on the level of harmonization in the country and the sophistication of sector planning and co-ordination mechanisms in place. In practice, in some countries partners are not willing to adopt shared processes and national plans.

⁶ Working Group on Global Health Partnerships: Report "Best Practice Principles for Global Health Partnership Activities at Country Level", High-Level Forum on the Health MDGs, 2005

One of the best practice principles is the accountability of the funder. GAVI will provide clear guidelines and responses to queries about HSS, as well as transparency in decision-making, allocations and disbursements. External financial audit is built into the plan for HSS.

3.8 Beneficiaries and Equity

The expected benefits of HSS fall into three main categories:

- *The primary beneficiaries will be the additional children and women immunized, who will have a reduced risk of morbidity and mortality. This in turn brings social, educational and economic benefits. Although HSS focuses on the measurement of DPT3 and measles immunization, the benefits are not disease specific – a stronger health system has the potential to increase and sustain increased coverage of all immunizations.*
- *Public health benefits. The advantages of sustaining high coverage should not be underestimated. A country with fluctuating immunization coverage levels – sometimes very high, sometimes dipping – can lose many of the population-wide benefits of immunization in terms of herd immunity. This proposal concentrates on developing systems which can consistently deliver high levels of coverage.*
- *The entire population will benefit from *improved capacity to deliver other health services.**

HSS enhances **equity** because poor people are disproportionately affected when public sector health systems do not function well. Some may not access any care; others may use expensive and/or ineffective services. High spending on health care is a common reason for families to fall into poverty, and to remain there. The poor are unlikely to use preventive services unless they are user-friendly, with low costs in terms of time and money. Poor people thus benefit when the basic health system is improved and is accessible, especially in the periphery⁷.

Another pro-equity aspect of HSS is that the burden of child mortality (and many other health indicators) is adversely distributed across income groups.⁸ Additional coverage of the population benefits the poorest because they are the least likely to be immunized and the most vulnerable to the diseases.

⁷ The World Bank 2004, World Development Report 2004: Making Services Work for Poor People

⁸ Gwatkin et al, Series on Socio Economic Differences in Health, Nutrition, and Population. Health Nutrition and Population, Poverty Thematic Group, World Bank. Various dates, circa 2000.

Section 4 Monitoring HSS

This section describes the monitoring of country activities and achievements. Global evaluations of GAVI are covered in Section 5.

There is a strong emphasis in all HSS processes on monitoring performance - countries have to justify and later demonstrate the link between their proposed activities and immunization coverage. This is stressed in the application process, the review of applications and in the monitoring framework.

GAVI has chosen a simple and clear indicator for its *end goal* of vaccinating all children against common diseases - DPT3 coverage. HSS support is one means of achieving this goal - therefore HSS will be monitored and evaluated against this indicator.

In addition to district and national DPT3 coverage, it is proposed that *routine measles vaccine coverage* is introduced as an outcome indicator. It is also proposed to use the *under 5 child mortality rate* as an outcome indicator, whilst realising that a multitude of factors influence this and that improved child mortality should not be a condition for country support. Child mortality in this sense is being used as a sign of improvements beyond the immunization program.

Many investments in health systems can only be expected to affect DPT3 coverage in the medium to long term (e.g. 3 or more years), so this indicator is less relevant in the short to medium term. Monitoring progress - from initial investment, via outputs to outcomes in terms of coverage - requires *process* indicators.

HSS will support a variety of different types of investments based on individual country needs. It is thus impossible to provide a fixed set of indicators for monitoring and evaluation of the process. Process and output indicators and targets will be identified by each country in its application – these will be rigorously scrutinised by the Review Committee in terms of quality, relevance and practicality.

The *Health Metrics Network* is a new global health partnership with the aim of supporting countries to strengthen their health information systems. The HSS process, as well as GAVI in general, will further develop monitoring and evaluation mechanisms in close collaboration with the Health Metrics Network.

4.1 Types of indicators

HSS support can be divided into three notional phases.

- short term - when the actual investments are made
- medium term - when *outputs* may be expected
- long term - when *outcomes* may be expected.

Indicators to monitor progress will be identified by countries in their application in the following way:

- *Short term* (up to 3 years): Process indicators, e.g.:
 - number of people for training
 - number of vehicles bought
 - value of funds transferred to districts
- *Medium term*: Output and capacity indicators, e.g.:
 - number of facilities with trained health workers in place
 - % of districts with functioning vehicles
 - and other relevant district performance data already used by the Ministry of Health.

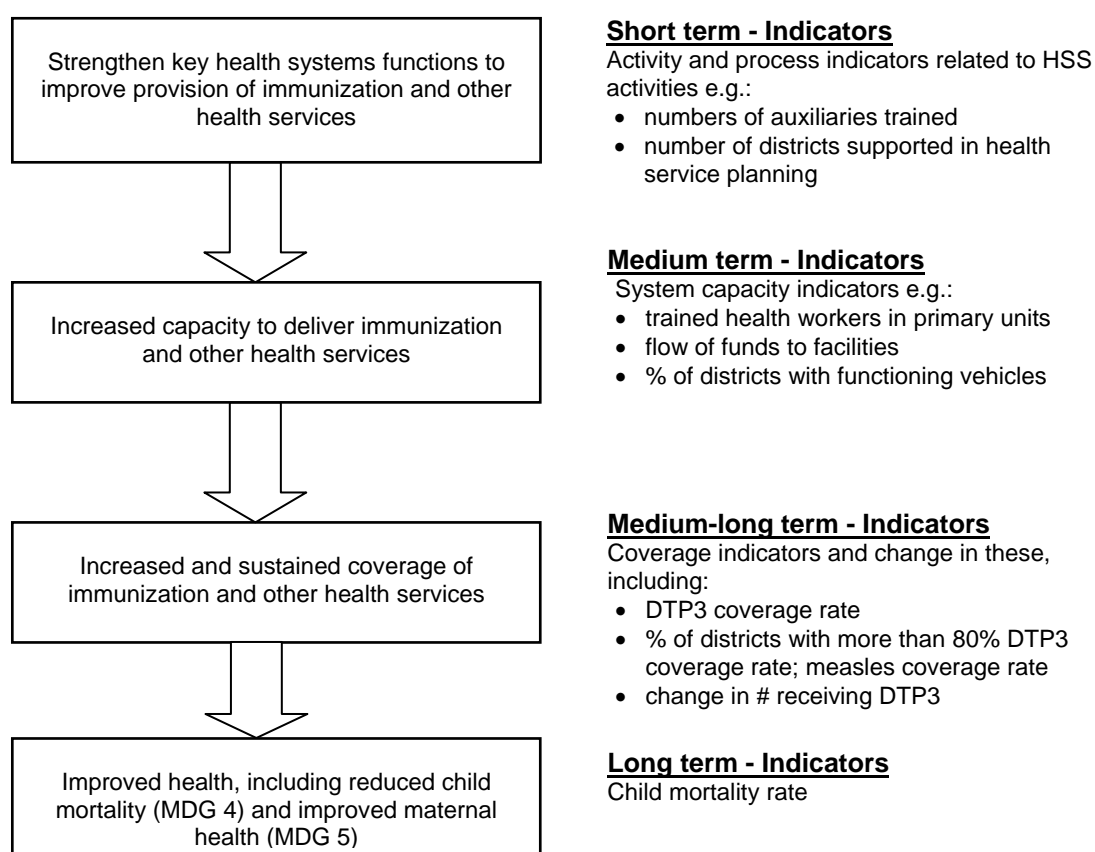
- *Long term:* Outcome indicators, e.g.:
district level DPT3 coverage (key equity indicator)
other measures such as district routine measles coverage and ultimately improvements in the child mortality rate.

The six main data sources for health information are either population-based (census, vital registration and surveys) or related to health service provision (disease surveillance, health facility records, administrative records). HSS monitoring may draw on any of these.

Most Ministries of Health already use some performance data, including at district level. HSS indicators should be in line with these where possible. Core indicators recommended by the Health Metrics Network should also be used wherever possible.

Figure 2 shows how these indicators relate to the conceptual framework presented in Figure 1.

Figure 2 *Monitoring progress against the conceptual framework for HSS*



Baseline data is required for the application to be approved and funding released. The requirements will be worked out between each country and GAVI as part of the negotiations (and/or technical support) after applications have been approved by the Board.

Countries with a recent Demographic and Health Survey will be able to use relevant data on immunization coverage and mortality rates as part of their baseline data for HSS support.

4.2 Monitoring and Evaluation Responsibilities and Processes

Global level responsibilities:

- The Launch Team will be responsible for monitoring the process during the first phases of HSS and supporting countries in identifying indicators and realistic targets. (The role of the Launch Team is explained in Section 5.)

- The GAVI Secretariat will review country reports against plans on an annual basis and compile a global report, as for other GAVI funding streams.
- The Secretariat may invite the Independent Monitoring Committee to assess country progress and identify cases for remedial support or the termination of funding.
- The Steering Committee will review findings across countries to identify problems and consider how these can best be addressed.

Country level responsibilities:

- MOH will be responsible for monitoring according to the HSS plan and for reporting to GAVI.
- The ISS and/or country facilitator will be expected to act if progress is significantly off-target.

Countries will report annually as part of their regular reporting to GAVI, using the reporting arrangement agreed as part of the application process. Review of country reports will be done on an annual basis as part of the general review. Countries can request GAVI to align with their financial year - this will mean reports coming in at different points in the calendar year.

As far as possible, HSS monitoring will be linked to processes for monitoring other aspects of health systems development. Some countries have an annual joint review of their sector plan. If possible, HSS should be reviewed as part of this process – this minimises transaction costs to the country and helps to identify how well HSS fits in with activities supported from other sources. Where there is not a sector-wide review, there may well still be scope to work on some form of joint review, perhaps of the basic health services.

Section 5 The Costs and Global Management of HSS

5.1 Costs

It is not possible to calculate individual countries' financial need for HSS support - it is simply not known what interventions are required in each country, and what the associated impact on immunization coverage would be. But whatever the exact costs, GAVI cannot meet all the funding needs.

It is therefore proposed that GAVI allocate a maximum level of funds to HSS, to be available to all GAVI-eligible countries. A proportion of these funds will be notionally allocated to each country (as an alternative to an approach based on specific proposals or estimates of needs).

The maximum level for HSS support depends on the funds available from GAVI through existing sources and the new International Financing Facility for Immunization (IFFIm). GAVI has estimated that approximately half of the new IFFIm funds will be allocated to systems related activities – with some **US \$800 million available for the first five years of HSS (2006-2010)**⁹. This compares to about US \$340 million committed to ISS in Phase 1.

As this is a new window of support, a phased approach has been adopted to ensure that GAVI has an opportunity to review success before all GAVI countries begin to receive support. This approach ensures that GAVI has the opportunity to assess impact and review processes before all the \$800 million has been disbursed. The first evaluation will occur after year 3, in early 2009, when some countries will have been receiving funds for two full years.

The allocation of funds between countries will be based on the annual number of births and on national income (whether the country is above or below \$365 per capita gross national income). This \$365 threshold is the same as for the Bridge Financing. Using this approach, \$800 million means between \$3 and \$3.4 per newborn per year for the countries above the \$365 threshold and from \$5.1 to \$6 for countries below the threshold (depending on how much weighting is given to income in the allocation).¹⁰ Box 2 puts these sums into perspective by making a comparison with a well-known system strengthening project in Tanzania.

This approach intentionally differs from that in ISS, which rewards only increases in coverage, and hence offers most to countries that have low coverage and manage to improve it. HSS complements this by recognising the continuing demands on countries to *sustain* coverage.

This allocation mechanism enhances equity because (a) it is based on demographic need and (b) the poorest countries are allocated more money "per unit of need". A number of equity criteria and design possibilities were examined during the development of HSS - the recommended method was chosen as both equitable and practical to implement.

From the \$800 million, it is estimated that approximately \$16 million (2%) will be needed for managing HSS. This is explained in more detail in section 5.2.

⁹ This is based on a maximum of \$1.8 billion allocated for HSS over the 10 year period from 2006-2015, and an assumption that funds will begin to be disbursed to countries from the beginning of January 2007 (with approximately \$200 million per year).

¹⁰ This assumes no allocation for India, as its budget allocation is separate. No weighting for income would provide about \$3.9 per newborn. The two separate weightings assume that low income countries receive 150% more funds or they receive 200% more.

Box 2 Comparing funding – TEHIP and HSS

The Tanzania Essential Health Interventions Project (TEHIP) is an example of how evidence-based system strengthening can improve a population's health status. Whilst accepting that TEHIP is exceptional – for example in terms of the level of technical support – this well-documented case does provide some idea of the costs of system strengthening.

TEHIP focused on developing evidence-based policies and practice, particularly through the routine use of local information. Decision-making was decentralised, and practical management tools were used to improve this decision-making. Child mortality in the two project districts fell by about 40% in 5 years (from about 35 to about 20/1,000 in a total population of 700,000); and death rates for men and women between 15 and 60 years old declined by 18%.

During the same period, the health indicators for non-project districts in Tanzania, and in fact across Africa, had been stagnant.¹¹ The project concluded “it is possible to begin to improve health significantly while working for more substantial increases in budgets, provided that resources are allocated more rationally and the system is strengthened.”

The cost of TEHIP over the first 4 years averaged \$0.92 per capita per year (as a top-up to the district budget). HSS will provide at least \$5.1 per newborn in the poorest countries – or about \$0.15 per capita per year.

Comparing HSS with TEHIP funding gives some idea of the scale of HSS funding:

- Per capita, it is about one-sixth the level of TEHIP funding.
- HSS funds will need to be spent on focussed activities with a clear link to immunization. The themes are intended to provide guidance for this.
- HSS alone will not solve health system shortcomings. It needs to complement other sources of support. This is why there is a strong emphasis on harmonization and alignment in this proposal.

5.2 Managing HSS

Key project management tasks for HSS include:

- supporting the application process (including ensuring countries have any necessary technical support)
- reviewing applications (an independent review process, and a mechanism for supporting countries asked to re-submit)
- setting up arrangements for the regular release of funds and reports on the use of funds
- ensuring progress is monitored on a regular basis, with spot checks as required
- deciding on measures to take when performance is unsatisfactory
- ensuring technical back-up is available as required
- communicating with partners and countries, and harnessing the inputs of partners
- ensuring that HSS as a whole is audited and evaluated, and appropriate adjustments made

At the global level, the **GAVI Secretariat** has the key role in managing HSS including the application process, disbursing funds, monitoring and ensuring technical support is available. For HSS, the Secretariat will be supported by:

¹¹ TEHIP report April 2004 at www.idrc.ca/tehip

- The proposed **Launch Team**. This team is required to cover the significantly higher workload during the first 12 - 15 months of HSS. The Launch Team will ensure that all relevant governments and other partners are well informed about HSS; make recommendations about the best ways to involve partners; support the first pathfinder countries with their applications (see below); and ensure that the required management systems are set up. The team will review the application process, country guidelines and assessment tools for analysing systems constraints. Lessons will be learnt from the first year of HSS and applied to the second wave of countries applying for support. The Launch Team will be located in the GAVI Secretariat, to ensure co-ordination with existing country support.
- The **HSS Steering Group**. Key partners will be invited to participate. The Steering Group will help to guide the evolution of HSS, especially in its first year.

In the first year of HSS, a number of **pathfinder countries** will work closely with the Launch Team – these countries will be the first HSS applicants. This approach will allow tools to be tested; lessons to be learnt about the types of support likely to be requested; and estimates to be made of the time and technical support required to submit an application. The pathfinder countries can then play a role in supporting others in the region.

The Board is asked to consider two options related to pathfinder countries. The second option is a more actively-managed approach than the first.

- Pathfinder countries can volunteer themselves because they are interested in applying for HSS at an early stage.
- The number of pathfinder countries should be identified in advance – 10, for example. The Secretariat should be actively involved in the selection of these countries.

The overall cost of HSS in the first phase (2006-2010), will depend on the approach adopted by the Board regarding pathfinder countries.

If countries are allowed to self-select to pathfinder status, it is estimated that approximately a third of countries will apply as pathfinders in 2006 (and receive 4 years support); another third will apply in 2007, and another third in 2008. All these countries would receive support until the end of 2010, when HSS support would be reviewed by the Board. The maximum amount of funding required for HSS in this case would be about \$573 million (including management and technical support costs).

If 10 pathfinder countries are selected, prepare their applications in 2006, and receive funding from 2007-2010, up to about \$300 million would be required (including management and technical support costs) for HSS.

GAVI will ensure the **Independent Review Committee** for HSS applications and the **Independent Monitoring Committee** have an appropriate skill mix, including health systems, immunization and primary health care expertise.

The performance of HSS as a whole will be thoroughly assessed. Two independent **evaluations** will be commissioned, with the first after 3 years in 2009. The preliminary evaluation will allow lessons to be learnt from the early implementation stages. This in effect reduces the riskiness of HSS – if necessary, substantial changes can be made in year 4.¹²

GAVI reserves the right to ask for a **financial audit** at any time, so that fiduciary concerns can be addressed promptly.

¹² In the first instance, HSS support will be available from 2006 until 2015. This document only considers HSS until the year 2015. If applications for five year periods are to continue after 2010, the situation needs to be re-assessed by then.

Provision of **technical support** to countries is the subject of another paper for the December 2005 Board meeting. Detailed mechanisms are thus not proposed here.

However, a preliminary estimate for **HSS management and technical support costs** has been calculated at \$16 million over 5 years¹³. A breakdown is given in the table below.

Area of management or technical support	Estimate for 5 years
1.1 Launch team for 15 months	\$0.67 million
1.2 Secretariat management post launch phase	\$0.84 million
1.3 Evaluations and financial audit	\$1.47 million
Sub-total management costs	\$2.98 million
2.1 Technical support to proposals	\$3.00 million
2.2 Technical support for implementation	\$7.50 million
2.3 Remedial support (as required)	\$2.52 million
Sub-total technical support	\$13.02 million
Total	\$16 million (2% of total HSS)

¹³ This assumes that major requirements for technical support for implementation will be built into the HSS proposals from countries.

Section 6 HSS in the wider context of GAVI and its other windows

This section addresses four questions:

- Why should GAVI – with its clear focus on immunization – be involved with health systems strengthening?
- Is HSS consistent with GAVI's principles and milestones?
- What is the relationship between HSS and GAVI's Immunization Service Support window?
- Is HSS sustainable?

6.1 Justification for Support to Health Systems Strengthening

The case for health systems strengthening is based on the argument that robust health systems are necessary for sustained high immunization coverage. This reasoning (that specific technical gains need to be backed up by strong health systems) is endorsed by a number of recent publications and reports on child health services and health sector support at the district level. The example quoted below is from the 2003 *Lancet* series on global child survival:

From the Bellagio Study Group on Child Survival:

“The second prerequisite [for effective action to reduce child mortality] is strong health systems. Even a cursory review of successful programs in the past indicates that many were quite independent of health systems. More in-depth analysis, however, points to the limited overall effect and sustainability of such short-term, disease-specific approaches, and has resulted in repeated calls for strengthening health systems as a basis for sustainable gains in public health.¹⁴ the longer-term goal must be systems of public health that are capable of defining needs, generating resources, managing programs and people, delivering cost-effective services, and gathering and using data to improve the effect of their efforts. One reason for slow progress in concrete actions to improve health systems might be that the scope of generic health-system interventions are too broad, encompassing all functions and potential beneficiaries. Child survival programs can provide a needed focus for action, with swift and measurable progress as a result of improved health systems.”¹⁵

In short, the argument is that well-crafted systems support can have a positive and significant impact on health outcomes, including immunization coverage.

Immunization is widely accepted as being one of the most cost-effective health interventions available. Developing an *economic justification* for HSS, however, is not so straightforward. One reason is that HSS will cover a broad range of activities because it relies on country-specific plans. The second reason is that the economic case for health systems strengthening is notoriously difficult to make. According to the *World Health Report 2000*:

“Many questions about health system performance have no clear or simple answers – because outcomes are hard to measure and it is hard to disentangle the health system's contribution from other factors.” (page xi)

Given the diversity of country responses to HSS and the limited data on the extent that health system improvements impact on immunization performance, it has not been possible to assess HSS in terms of cost effectiveness.

¹⁴ The references cited here are The World Health Report 2000 and Jeffrey Sachs, *Macroeconomics and health: investing in health for human development*. WHO, 2001.

¹⁵ “Knowledge into action for child survival”, *The Bellagio Study Group on Child Survival*. The Lancet, Vol 362, 2003. The Bellagio Group included expert members from the World Bank; David and Lucile Packard Foundation USA; Ifakara Health Research and Development Centre, Tanzania; WHO; Universidade Federal de Pelotas, Brazil; ICDDR, Bangladesh; Johns Hopkins University, USA; Aga Khan University, Pakistan; Rockefeller Foundation; Cornell University, USA; UNICEF; Instituto de Investigación Nutricional, Peru; London School of Hygiene and Tropical Medicine, UK; Makerere University Institute of Public Health, Uganda; Bill and Melinda Gates Foundation; Center for Disease Control and Prevention, USA.

6.2 HSS and GAVI's principles and milestones

HSS adheres to GAVI's core principles. The GAVI concept of a *value-added investment* implies that GAVI resources innovate, activate or catalyse necessary change, according to the following principles:

- *Unique*: HSS will be unique in its focus on strengthening health systems at district level and below in ways which contribute to the capacity to deliver immunization and other health services.
- *Catalytic*: HSS support is catalytic in that it enables *capacity* to be strengthened at service delivery levels. Any gains in immunization coverage can thus be sustained in the longer term, and further increases made. HSS will allow countries to address underlying structural issues in their health systems.
- *Innovative*: HSS encourages countries to identify innovative approaches to improving coverage of basic health services, including immunization.
- *Time-limited*: HSS will operate for the period 2006-2015, with grants related to country planning and budget cycles.

HSS funding is also *predictable* in that it does not have an early cut-off point for poorly performing countries. A review mechanism and technical support allow plans and strategies to be monitored and adapted as necessary.

The support will be *performance-based*. Countries need to report on progress against pre-defined indicators and targets at regular intervals. Countries which do not show any progress, even after technical back-stopping from GAVI, will have their HSS support terminated.

Clearly HSS contributes most directly to the GAVI milestone "by 2010 or sooner all countries will have routine immunization coverage at 90% nationally with at least 80% coverage in every district". However because HSS deals with immunization systems in general – not for a particular vaccine – it will also contribute to the GAVI milestones relating to hepatitis B, Hib vaccination and a polio-free world.

6.3 HSS and the Immunization Service Support window

GAVI recognised the importance of supporting health systems in Phase I and hence introduced Immunization Services Support (ISS). Initially, ISS funds are allocated based on estimates of expected increases in immunization coverage - later this is based on actual performance, at a rate of US \$20 per additional child vaccinated. Countries receiving ISS support are free to allocate the ISS funds as they choose in order to improve their immunization program - no plans are required in advance by GAVI. Countries report on the use of funds as part of their annual progress report to GAVI.

A review of ISS in 2004 showed that country managers appreciated the flexibility in the funding arrangement and that ISS had been used for a variety of purposes, generally within the immunization program and often at a district level. In terms of results, some countries had succeeded in increasing coverage while others had not.

The GAVI Board has decided to continue ISS support in Phase 2 and extend it to countries with coverage above 80% (which were ineligible in Phase 1). The Board recognised this would not be sufficient to achieve the objectives of increasing and sustaining coverage and therefore asked for development of the HSS funding proposal.

Key differences between ISS and HSS can be summarised as follows:

Characteristic	ISS	HSS
Flexibility to use funds	Use not restricted and no plan required for spending	Use not restricted but themes suggested and plans required
Management of funds	Usually under immunization program with ICC oversight	Integrated with other health sector funding processes; oversight of Ministry of Health Planning Department or similar
Endorsement of applications	ICC partners to sign application	Ministry of Finance and other relevant partners to endorse applications
Response if plans / targets are not met	No funding provided next year. Hence limited predictability.	Funding alongside remedial review and restructuring of plans. Possible to end support after year 4 if poor performance continues
Harmonization and alignment	Processes for managing and reporting on ISS not usually harmonized or aligned	Should be harmonized and aligned with national plans and processes
Allocation of funds to country	Increase in numbers vaccinated with DPT3 over last year	Birth cohort and per capita income
Monitoring indicators	Only looks at DPT3 coverage	Process indicators, national and district DPT3 and measles coverage

The following similarities between HSS and ISS were agreed by the July 2005 GAVI Board as a basis for planning for Phase II:

- Available to all eligible countries (not just those with <80% DPT3 coverage)
- Country driven, firmly based on the needs and expressed requests from countries, based on analysis of key systems
- Flexible, taking into account the country specific situation regarding needs, as well as the channelling of funds
- Predictable and long term
- Performance based, but with possibility for weak countries to access more hands on support in order to improve capacity to improve their immunization performance
- Have low transaction costs for countries; any increase in transaction costs should be incurred at the global level or by partners
- Be harmonized and coordinated with support from other global health initiatives and health partners.

6.4 Sustainability

The sustainability of HSS is essential for securing the long-term impact of the support. Financial sustainability is clearly related to the overall funding of the health sector, which according to GAVI's definition includes resources from domestic sources and development partners¹⁶. Political commitment to health is essential, which is why HSS the Ministry of Finance is required to endorse an HSS application. Ministries of Finance are more likely to sustain expenditures which are 'on-budget' - i.e. reflected in the national accounts. GAVI will support this mechanism where possible.

HSS contributes to the sustainability of service delivery - in this case, the short- and long-term capacity to deliver immunization to all children. Capacity in this context means

¹⁶ GAVI definition of financial sustainability is: "Although self-sufficiency is the ultimate goal, in the nearer term sustainable financing is the ability of a country to mobilise and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity."

“the ability to plan and carry out activities, to increase and sustain certain health services and to be responsive to changing needs in the population served.”¹⁷

Linking capacity to sustainability, it is primarily the organization's *ability to produce certain desired activities and support functions* that should be sustained¹⁸.

For sustainability, there needs to be capacity. Capacity can be seen in terms of:

- individual capacity - training and skill development
- organizational capacity – the ability to make policies, plan, organise, implement etc.
- system capacity - the ability of the totality of stakeholders, both private and public, to deliver services.

HSS support is intended to build such capacity – and hence to promote the sustainability of health service provision.

¹⁷ Based on Paul S. Capacity building for health sector reform. Discussion Paper No. 5, WHO/SHS/NHP/95.8

¹⁸ Olsen IT. 1998. Sustainability of health care: a framework for analysis. *Health Policy and Planning*. 13 (3) 287–295.

Section 7 Risks and Issues

This proposal for HSS has been widely discussed with inputs from a range of partners through a specific HSS Reference Group. In the course of developing the proposal, many issues arose and were carefully debated. Alternative ways of designing HSS were considered – some of these are described in the “Point/counterpoint” section below. In addition the Reference Group was asked to identify the critical risks facing HSS – these are listed below, together with the measures proposed to minimise these risks.

7.1 Point/Counterpoint Analysis

All these points were raised by HSS Reference Group members as part of the process of preparing this proposal.

Point 1: GAVI should not get involved in HSS

Issue: HSS is too vague and too far from GAVI’s specialist area of immunization – there simply shouldn’t be an HSS. It won’t help countries because GAVI has no comparative advantage in this area. GAVI’s achievements will be diluted and non-attributable.

Response: In theory it is possible to pour more and more money into a narrowly-defined immunization program and to increase coverage and the number of vaccines administered. There are however, two problems with this argument:

- The immunization system inextricably relies on non-immunization resources to function. Examples include clinics, managerial staff and a government accounting system. Without balanced investment, the immunization program will suffer critical weaknesses. A GAVI without HSS ignores this balance.
- Single-program service delivery is an expensive way of delivering services and is inappropriate in resource-poor contexts. Immunization programs should be sharing their resources with other primary health care resources to improve child and adult health. GAVI without HSS could be accused of supporting an unsustainably separate and expensive approach to immunization and disregarding other key health issues.

HSS does involve some challenges – describing it clearly so that good proposals are forthcoming; ensuring that appropriately-skilled technical support is available; making plausible connections between systems activities and immunization coverage and quality. These are dealt with in detail in other sections of this proposal.

HSS will bring advantages to countries – HSS would mean additional money for systems issues, as long as the proposal can justify that it will bring benefits to immunization. GAVI’s focus on performance provides incentives for countries to deliver on their plans and ensure that their system strengthening efforts are focussed towards measurable impact on local service delivery. GAVI is also willing to commit funds for longer than some donors and align its funding to national planning cycles.

Point 2: Rather than create HSS, ISS could be given more resources and perhaps changed in some aspects

Issue: GAVI funds through ISS already offer considerable flexibility to countries and are based on the GAVI principle of rewarding performance. ISS should be expanded and could be altered, for example to have a special facility for non-performing countries.

Response: ISS is essentially a reward for improved performance – there is great flexibility about what the funds are used for. In practice, ISS funds tend to have been used by National Immunization Managers for practical immunization-specific resources. Because it rewards

improvements in coverage each year, ISS cannot provide large sums of money over many years for most countries – as significant improvements are only possible to achieve for a few years. It would not be appropriate for ISS to be a significant part of immunization funding – it is better to keep ISS as an attractive, proportionate reward for good work done.

There are two important roles which ISS does not fulfil:

- It does not encourage or reward sustaining high levels of coverage – yet this is vital if the full public health benefits of immunization are to be realised.
- It does not encourage health managers to identify and tackle underlying barriers to higher coverage and does not provide technical support.

HSS is intended to tackle these issues not covered by ISS. One way to help countries is to have as few changes to existing, successful funding schemes as possible. Therefore not changing ISS is a virtue. It is popular with countries and is elegantly simple. The only change proposed so far is the eligibility criteria, so countries with high coverage can apply for ISS.

Point 3: Resource allocation amongst countries

Issue: Some partners recommended that the allocation of finances amongst eligible countries should reflect the number of un-immunized children in that country (rather than all children). This can be seen as more equitable because it would target resources to where they are most needed. Specifically, finances could be allocated according to the size of the birth cohort, weighted for the number of un-immunized children through the formula (1-DPT3 coverage). This would benefit most large countries with low immunization rates and countries in extreme crisis. Increasing coverage in these countries is vital if GAVI is to meet its global coverage objectives.

Response: Countries with persistently low coverage are an issue and it is important that their needs are met. HSS is not the tool to meet this need. It is thus recommended that the Board consider developing an additional mechanism to support persistent low-performing countries.

There are several reasons for allocating resources according to the size of the birth cohort, with a stronger weighting for income less than \$365 per capita:

- Bridge financing is calculated in the same way - using the same system makes it much easier for countries to understand.
- It is equitable in the sense that all children receive the same notional amount, except that children in the poorest countries receive more.
- Allocating finances according to the number of un-immunized children appears to reward low coverage - in conflict with the GAVI principle of rewarding good performance.

Point 4: HSS may be used for unsustainable inputs such as salary top-ups for health workers

Issue: GAVI should explicitly exclude paying salary top-ups for health workers. Salaries for front-line health workers are indeed too low in many GAVI-eligible countries, but salary top-ups cause problems in terms of distorting national salary structures beyond the health sector and they are a short-term, unsustainable measure. Salary top-ups and/or per diem payments for polio activities have not led to increased performance in some countries. There are alternative measures to deal with low salaries – for example there are many effective and sustainable incentives for better performance, including peer pressure, special recognition, longer holidays and other special privileges.

Response: Many of these points about salary top-ups are salient – but it was considered inappropriate to be prescriptive about this rather specific issue in the investment proposal. The underlying principle is that countries should design the intervention and should be able to justify

it. Any proposals will be scrutinised by country partners and the Independent Review Committee.

Point 5: Waste management

Issue: Waste management means the appropriate disposal of consumables such as immunization needles and syringes. It should be a separate HSS theme – because it is important per se and because it was explicitly requested by countries during the consultation process. It is wrong to encourage more vaccines to be given to more people without ensuring the safe disposal of the potentially dangerous consumables.

Response: The importance of waste management – and the fact that this is a high priority in many countries – is fully acknowledged. Effective waste management is a public good and is part of the wider health system (since not all waste relates to immunization). It does not directly contribute to immunization coverage, but is clearly an element in quality service provision. Whilst waste management is too specific to be a theme for HSS, countries are free to apply for funds to strengthen waste management.

7.2 Critical Risks

During the October 2005 meeting of the HSS Reference Group, a number of critical risks were identified and discussed. A critical risk is something that should it occur, would derail or substantially impede achievement of the outcomes of HSS - the “make or break” risks.

Risk 1

HSS makes ambitious demands on the national and global infrastructure of governments and partners. The risk is that **countries, partners and the GAVI Secretariat will be unable to meet these demands and HSS will be under-managed and inefficient.**

It is correct that HSS entails increased management costs. This is justified because it is vital to ensure due-diligence and right that resources should be devoted to enabling country-specific activities. The following *risk minimization measures* are included:

- Funds have been specifically earmarked for management and technical support in this proposal. This includes a launch team, with a major communication function to governments and partners. GAVI is also working with partners on setting up arrangements for technical support to countries for both design and implementation.
- Specific plans will be made so that lessons will be learnt as HSS progresses. This includes pathfinder countries in 2006 and an independent evaluation after three years.
- Lessons will be learnt from the HSS experience of the Global Fund to fight AIDS, TB and Malaria. This has happened during the development of this proposal, when lessons from the first round of Global Fund HSS proposals were reviewed and discussed.

Risk 2

Support to health systems at the country level will be fragmented. There is an inherent tension between describing the health system as a core function and supporting this with fragmented pots of money.

Whilst HSS will inevitably create some new systems of applying and accounting for funds, the main *measure for minimising this risk* is to keep the separate procedures as streamlined as possible.

Specific measures to minimise this risk include:

- HSS funds should use existing financial management procedures and timetables whenever possible. This includes country planning cycles, pooled funds and SWAp processes.
- Likewise, existing documents which identify problems or plans and report on outputs should be used whenever possible.

In short, this proposal adheres to the Best Practice Principles for Global Health Partnerships (GHPs) developed by the Working Group on GHPs to the High-Level Forum on Health MDGs.

Risk 3

Funders of GAVI will be disappointed because HSS will not be able to demonstrate convincing achievements quickly enough.

Monitoring HSS is a challenge. Monitoring current GAVI-funded activities has already proved difficult, and HSS will cover a broad range of activities. This *risk has been minimised* by emphasising the importance of monitoring credible indicators identified by countries themselves at different stages in the process, while continuously monitoring DPT3 coverage.

The choice of themes for support will help to build up experience and evidence on how to implement and monitor strengthening specific aspects of systems.

Another dimension of this risk is the possibility that the actual achievements of HSS are not significant, perhaps because of a lack of harmonization with other actors, or simply because HSS is too small relative to the scope of the problem. Again these risks point to the importance of the basic principles underlying HSS – good quality support for country-specific proposals and review, and partners which are actively committed to making HSS work. Whilst HSS resources will never be enough to overcome all the systems constraints, the resources should be used to deal with critically important bottlenecks that will allow some improvement.

It is crucial that funders of GAVI are made aware from an early stage that they cannot expect major outcome results after a couple of years.

Risk 4

Fungibility - HSS money displaces finances from government and other development partners¹⁹.

In a situation with a high degree of harmonization between development partners, the risk of fungibility is reduced. However, this also requires a solid overall government plan for the sector, for which agencies either pool funds or divide responsibilities for funding amongst themselves and with government. For countries with strong resource constraints, fungibility should probably not be seen as a major issue, as long as their funds are used for other important tasks.

Certain features of GAVI and HSS minimise the risk of fungibility:

- HSS is non-prescriptive and aims to address country defined needs. This maximises the chances of strong country ownership of, and commitment to, the activities being funded. This is the best defence against fungibility.
- GAVI funding has been shown to be additional to existing immunization funding and not replacing other funding. However, this will become more difficult to measure the longer GAVI exists.

¹⁹ Fungibility is the idea that aid pays not for the items against which it is accounted, but for the marginal expenditure it makes possible. If financial support is fungible it may simply be used as a substitute for existing spending – and hence it may displace an existing government commitment or that of other partner agencies.