



GAVI/12/309/mi/mg/ac

The Minister of Health and Social Welfare
Ministry of Health and Social Welfare
P.O. Box 9083
Dar-es-Salaam
United Republic of Tanzania

20 December 2012

Dear Minister,

Tanzania's 2012 application to the GAVI Alliance for health system strengthening cash support

Following a meeting of the GAVI Executive Committee (EC) in July 2012, I am pleased to inform you that Tanzania has been approved for GAVI Health System Strengthening (HSS) cash support. This approval is dependent upon satisfactory response to the clarifications requested by the Independent Review Committee (IRC) in the attached Annex C. As you know, the IRC has recently found that your initial response was insufficient and has set out the areas remaining for clarification (Annex C1). The clarifications must be satisfactorily completed within 60 days of the date of this letter, although because of the intervening holidays, I am content to extend the deadline exceptionally, to the end of February 2013.

Further, based on the GAVI Board decision in November 2011 to roll out performance based financing (PBF) as the default mode of cash-based support for HSS from 2012, I would like to inform you that GAVI's HSS support for your approved application will be implemented through the PBF instrument. This is designed to provide incentives to improve immunisation outcomes by strengthening health systems, rewarded by linking the cash support to performance. Please see Appendix B for initial information.

More comprehensive information on PBF, including a detailed implementation framework, will be shared in coming months. This will be complemented by additional information sessions at sub-regional or country meetings in 2013.

Please do not hesitate to contact my colleague Charlie Whetham at cwhetham@gavialliance.org or email pbf@gavialliance.org if you have any questions or concerns.

Yours sincerely,

A handwritten signature in blue ink, reading "Hind Khatib-Othman".

Hind Khatib-Othman
Managing Director, Country Programmes

Attachments: Appendix A: Decision Letter for Cash Support.
Appendix B: Update on GAVI's performance based funding instrument.
Appendix C: Report of the Independent Review Committee (IRC)
Appendix C1: IRC response to your most recent clarifications submitted
Appendix D: GAVI Alliance Terms and Conditions.

cc: The Minister of Finance
The Director of Medical Services
Director Planning Unit, MoH
The EPI Manager
WHO Country Representative
UNICEF Country Representative
Regional Working Group
WHO HQ
UNICEF Programme Division
The World Bank

DECISION LETTER FOR HSS CASH SUPPORT
LETTRE DE DÉCISION POUR LE SOUTIEN SOUS FORME D'ESPÈCES

APPENDIX A

Cette lettre de décision décrit les conditions d'un programme

Complétez en français

1.	Country: Tanzania <i>Pays</i>
2.	Grant number: 1215-TZA-10d-Y <i>Numéro d'allocation</i>
3.	Decision Letter number: 1 <i>Numéro de la lettre de décision</i>
4.	Date of the Partnership Framework Agreement: <i>Date de l'Accord Cadre de Subvention:</i> Not applicable
5.	Programme Title: Health Systems Strengthening (HSS) <i>Titre du programme : Renforcement des systèmes de santé (RSS)</i>
6.	HSS terms: <i>Conditions du RSS</i> The ultimate aim of HSFP support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in: • The GAVI HSFP guidelines • The GAVI HSFP application form • Country's response to the HSFP IRC's request for clarifications. All disbursements under GAVI's HSS cash support will only be made if the following requirements are satisfied: • Availability of funding; • Submission of satisfactory Annual Progress Reports (APRs); • Approval of the recommendation by an Independent Review Committee (IRC) for continued support by GAVI after the first year; • Compliance with any TAP requirements pursuant to the TAP Policy and under any Aide Memoire concluded between GAVI and the Country; • Compliance with GAVI's standard terms and conditions (attached in Appendix [D]); and • Compliance with the then-current GAVI requirements relating to financial statements and external audits, including the requirements set out for annual external audit arrangement applicable to all GAVI cash grants as set out in the aide memoire. The HSS cash support shall be subject to GAVI's performance-based funding. Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved grant budget (the initial Annual Amount) as an upfront investment. After the first year, 20% of the programme budget (subsequent Annual Amounts) will be subject to performance on immunisation outcomes. That is, countries will receive 80% of the programme budget based on implementation of the grant and additional payments will be based on performance on immunisation outcome indicators. Given that Country's DTP3 coverage was at or above 90% in 2011 based on WHO/UNICEF estimates, Country will be rewarded for sustaining high coverage with: • 20% of programme budget for maintaining DTP3 coverage at or above 90% • 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage. Country will have the opportunity to receive payments beyond the original approved budget amount, for exceptional performance on the same immunisation outcomes. The performance payments under the performance-based funding shall be used for solely for activities to be implemented in the country's health sector. Performance payments shall not be used to meet GAVI's co-financing requirement.

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The implementation framework for performance based funding of GAVI shall apply to the HSS cash support.

7. Programme Duration¹: 2012–2015

Durée du programme:

8. Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement, if applicable):

Budget du programme (indicatif) (sous réserve des conditions de l'Accord Cadre de Subvention):

Note that with PBF, annual disbursements may be more or less than this amount after the first year (see section 6 above).

	2012	2013	2014	2015	Total ²
Programme Budget (US\$) <i>Budget du programme</i>	3,786,840	4,544,903	4,312,802	3,299,701	15,944,246

9. Indicative Annual Amounts (indicative): The following disbursements are subject to the conditions set out in sections 6,10 and 12.

Montants annuels indicatifs (indicatif) (sous réserve des conditions de l'Accord Cadre de Subvention):

	2012
Annual Amount (US\$)	3,786,840 ³

10. Documents to be delivered for future disbursements:

Documents devant être présentés pour des décaissements futurs:

The Country shall deliver the following documents by the specified due dates as part of the conditions to approval and disbursements of the future Annual Amounts.

[Non applicable.] [Le pays devra présenter les documents suivants aux dates précisées dans le cadre des conditions d'approbation et de décaissement des futurs montants annuels.]

Reports, documents and other deliverables <i>Rapports, documents and autres</i>	Due dates <i>Date limite de réception</i>
Annual Progress Reports (APRs). The APRs shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well the PBF indicators as listed in section 6 above. The APRs should also include a financial report on the use of GAVI HSS funds (which could include a joint pooled funding arrangement report, if appropriate) which has also been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent, as well as use of performance payments.	15 May 2013

11. Clarifications: The Country shall provide clarifications to GAVI as previously communicated prior to the disbursement of the Annual Amount in 2013. GAVI will not release funding until it has received such clarifications.

Éclaircissements : [Le pays devra fournir les éclaircissements suivants à GAVI avant le décaissement du montant annuel en [ANNÉE]. [GAVI ne débloquera pas le financement avant d'avoir reçu les éclaircissements suivants.]

The clarifications are still pending. Please see Appendix C.

12. Other conditions: The following terms and conditions shall apply to HSS support.

¹ This is the entire duration of the programme. Ceci est la durée entière programme.

² This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table. Ceci est le montant total approuvé par GAVI pour la durée entière du programme. Celui-ci doit être équivalent au total de toutes les sommes comprises dans ce tableau.

³ This is the amount approved by GAVI

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Autres conditions :

All cash disbursed under HSS support will not be used for GAVI's co-financing payment requirements.

In case the Country wishes to alter the disbursement schedule over the course of the HSFP programme, this must be highlighted and justified in the APR and will be subject to GAVI approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process both in its technical process function and its support during implementation and monitoring of the HSFP programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed by,

Signé par,

On behalf of the GAVI Alliance

Au nom de GAVI Alliance



Name (Print): Hind Khatib-Othman

Nom (Majuscules)

Title: Managing Director, Country Programmes

Titre

Date: 17 December, 2012

Date

Update on GAVI's Health System Strengthening (HSS) cash support: Performance based funding instrument

GAVI's performance based funding (PBF) instrument is designed to incentivize countries to improve immunisation outcomes by strengthening health systems, rewarded by linking the cash support to performance. As approved by the GAVI Board in November 2011, countries approved for HSS grants in 2012 and onwards will be implementing their grants with the PBF instrument. Under the PBF instrument, GAVI's HSS cash support will be split into two different types of payments: a programmed payment, based on implementation of the approved HSS grant, and a performance payment, based on improvements in immunisation outcomes.

In the first year, all countries will receive 100% of the programme budget (approved grant budget) as an upfront investment. After the first year, 20 percent of the programme budget is no longer assured by making progress in implementation, but will be provided (along with the opportunity to obtain even more—see below) subject to performance on immunisation outcomes. That is, countries will receive 80% of the programme budget based on implementation of the grant and additional payments will be based on performance on immunisation outcome indicators. The indicators for determining performance payment are different based on whether a country's DTP3 coverage is at or above 90% (sustained high coverage) or below 90% (coverage in need of improvement) in baseline year (2011) based on WHO/UNICEF estimates. Performance payments will be as follows.

- Countries with DTP3 coverage at or above 90% at baseline will be rewarded for sustaining high coverage with
 - 20% of programme budget for maintaining DTP3 coverage at or above 90%
 - 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.
- Countries with DTP3 coverage below 90% at baseline will be rewarded for improving coverage with
 - \$30 per additional child immunised with DTP3, if DTP3 coverage increases
 - \$30 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases.

With the PBF rewards shown above, countries will have the opportunity to receive payments greater than the original approved programme budget, for exceptional performance on these immunisation outcomes (sustaining equitable coverage above 90% or improving coverage with key vaccines).

This PBF instrument offers countries the flexibility to use the reward payments within the health sector, based on the needs of the health sector, without having to provide proposed budgets or activities ahead of time. Requirements for reporting the use of these payments as well as verification for payments will be communicated in early 2013 along with a PBF implementation framework. Performance payments shall be subject to the same annual external audit arrangements applicable to all GAVI cash support, as outlined in the Aide Memoire, and management of these funds is to be performed in compliance with GAVI's Transparency and Accountability Policy.

At this time, there is no action required by countries. Country responsible officers (CROs) from the GAVI Secretariat will be in contact with you about the PBF instrument. Grant-specific HSS intermediate indicators will be decided jointly with countries in 2013, based on the same indicators included with your grant proposal. This is to support improved implementation and monitoring of the HSS grant.

Type of report: Report of the Independent Review Committee

Date reviewed: February 13-17, 2012

Country name: Tanzania

Type of support requested: HSS

Application method: Common Form

Country profile/Basic data

Tanzania	
Proposal duration	July 2012 - 2016
Budget required	US\$15,936,515
cMYP duration	2010-2015
National health strategy document included	Yes
National Health Plan duration	July 2009 – June 2015
Population (year)	45,040,000 (2010)
IMR	59/1000
DTP3 coverage (country/UNICEF)	91%/91%

1. History of GAVI HSS support

NVS and INS support	Approval Period
DTP-HepB	2002-2008
Penta	2009-2015
INS	2003-2005

Cash support	Approval Period
ISS 1	2001-2006
ISS 2	2007-2010

The country has not received HSS support before. It is one of the pilot countries in which the HSFP process is being tested and assessed.

2. Composition & functioning of the HSCC

The composition and role of the HSCC is adequate. It has been reviewed and re-organised especially in response to the IRC comments on the first submission of this proposal in 2011, to facilitate joint monitoring, oversight and management of GAVI and GF activities. A specific goal is to ensure maximum complementarity between the activities in similar areas. The composition of this committee is representative with the Ministry of Health chairing the meeting and the inclusion of a number of key stakeholders. The involvement of CSOs is limited to MCHIP a USAID funded organisation. There is a fair representation of partners in the committee though this can be improved to get more representation including that of CSOs.

3. Comprehensive Multi Year Plan (cMYP) overview

The objectives of the Tanzanian cMYP are in line with the GIVS Strategy and the sector planning. The cMYP amplifies the details of the strategies of accessibility to District Health with all facilities providing a complete package of essential health interventions

in according with the guidelines for their level, while community involvement will be strengthened to improve health articulated in the HSSP III. The strengths of the cMYP lie in the description of the challenges and the linked strategies to address these. The funding analysis has been completed and indicates the required resources and identifies the sources of the funds as well identifying gaps.

4. JANS review

5. Monitoring and Evaluation/Performance Framework

The required focus on EPI indicators is present. The Monitoring framework suggests indicators at three levels; impact, outcome and output. These indicators have an immunisation focus taking into account the quality and equity dimension. The process indicators appear appropriate. However for service delivery area 1.1 there is need to further define RED implementation as relates to the 5 components so that this definition is maintained for the standardized monitoring process. There are also indicators that will show the progress in the outputs of the activities planned. For SDA 1.2 on Stewardship and Governance the indicator is not appropriate.

In general, the indicators for the specific activities in Objective 1 are weak in light of the problems described below. Given the challenges and the basic weaknesses in the health system described in the cMYP, it would seem useful to use this opportunity to begin to identify indicators that can show whether and to what extent health system strengthening has occurred as a result of the activities undertaken.

6. Linkages to immunisation outcomes

In the HSS proposal there are 3 principal objectives:

Objective1: Improved immunization outcomes (coverage & quality) in the context of integrated health services, nationwide.

Objective 2: Increased community participation in the provision of immunisation services, particularly in rural and hard to reach areas.

Objective 3: Improved cold chain capacity and management.

There is a good description of the many health system constraints for immunisation outcomes. The proposal has noted that the use of the Building Blocks approach is quite recent; until now, most previous evaluations and reviews focused on programmatic or implementation level approaches rather than on a broader more systemic strategic approach. The proposal demonstrates a good understanding of health system constraints for immunisation outcomes. Many of these lie in the areas of human resource capacity deficiencies and availability and in the provision of adequate supervision and monitoring. However, as the proposal itself notes, there are many good policies and strategies in existence, but more often than not these are not known, understood, nor followed. It also recognizes that the development and utilization of any health systems strategies is a fairly recent development. The activities set out under Objective 1 seem specifically designed to focus the available human resource capabilities and orientations on immunization and immunization related activities. Thus, it is stated that “the objective aims at systems strengthening in areas that were identified in the 2010 EPI review to be key constraints for improving immunization outcomes in relation to human resource development (training and supervision); advocacy; management & leadership; monitoring, evaluation and operational research; and infrastructure.”

7. Action plan for immunisation results

Strengths:

Every effort has been made to show the relationships and linkages to the HSSPIII, the cMYP, as well as existing HMIS and Human Resource Development Plans. In general, the proposal's objectives and their associated activities are clearly described and well laid out. This is especially true for objectives #2 and #3; the gaps are described and the manner in which the proposed activities are intended to fill these gaps are specifically identified and described. These descriptions are generally followed up in the budget and the performance framework. The proposal also recognises the continuing challenges in the areas of monitoring and evaluation and the HIS and includes some activities to help address these.

The country has also provided relatively satisfactory responses to a number of issues and questions raised by the IRC assessment of the HSS proposal in September 2011.

Weaknesses:

- Objective 1 (focused on improving immunisation outcomes) and its activities tend to be a bit amorphous and not very easily understood as a coherent whole. The areas to be targeted are training and supervision, programme management and leadership support, microplanning support, the development and provision of IEC messages for increasing immunisation uptake, making available immunization data tools and equipment for the processing, analysis and transmission of data, and operational research. Examination of the budget shows that the activities to be actually funded are training (including the provision of refresher training), the evaluation of training materials, review workshops, microplanning support, advocacy meetings, the provision of Technical Assistance for financial management, performance monitoring, an immunization data tools review workshop, a data quality study and a data analysis workshop, and the acquisition of vehicles. The proposal had noted that there is need for programme specific HIS management and operational research for programmes like EPI; to this end the HSFP will "complement the general HMIS efforts with support for EPI specific data generation tools development, data quality assurance, data management interventions and operational research". Unfortunately, while some activities could be said to be relevant for the need for better programme management, several of the listed activities will not actually occur. Neither is it clear how any of this effectively addresses the plan to provide "data tools and equipment for the processing, analysis and transmission of data." There are therefore two difficulties here: one is that Objective 1 is little more than a mixture of activities with inadequate internal coherence; the second is that there is a lingering disconnect between proposed activities and the actual cost drivers in the budget. In reality, the largest portion [41.9%] of the funds for Objective 1 will go to the acquisition of transportation vehicles and for Planning and Administration [20.9%].
- A review of sections 4.1, 4.2.a and 4.2.b, which deal with the provision of electronic devices for improving M & E, reveals that the detailed budget and summary budgets do not match the costs described.
- Funds have been allocated for the provision of local technical assistance and programme management. However, their likely programme of work is insufficiently clear.
- Although highlighted as a need, little is said about Operational Research, what it might entail, and how those objectives are to be monitored and assessed.
- The government has said that it will absorb costs once the GAVI support has come to an end. However, in light of the noted declines in the expenditure on EPI and the

admitted difficulties in the country of satisfactorily meeting operational and recurrent costs, a question may be raised about how the high cost capital investment activities [cold chain equipment and facilities and vehicles] are to be maintained and sustained once GAVI support has come to an end.

- Management training has been scheduled for years 4 & 5. Given the need for programme management identified, what is the utility of doing this so late in the programme?
- The budgetary allocation for Planning and Administration is high. For objective 1, some 21% of that Objective's budget, and for the the full programme of work 15% have been so allocated. These are high especially as activities - such as the refurbishment of offices, the acquisition of air conditioners, etc - that may normally be found in this category already have line item allocations.
- With regard to the proposed purchase of 120 vehicles, there needs to be better justification of this in view of the fact that the Global Fund has already provided vehicles to be used for the delivery of integrated health services.
- There is no clear description of how the private sector will be part of the described activities.

There is a general issue that needs to be raised and follows from one of the general observations made in the cMYP. It has to do with the growing "weakness in the structural

foundation of the immunisation system." Manifestations of this are the difficulties with meeting the operational costs of running the system, the decline in allocations of funding to EPI at the central level, the continuing problems with staff recruitment and retention, and the real problems with data management. While the proposed activities

are easily in line with the strategies described in the various national plans and strategy documents, it seems important to ask about their real and longer term impact on the sustained strength of the health system. The proposed activities largely focus on training, some programme management, staff salary support, improving awareness levels at the community level, and improving the cold storage capacities and capabilities. It would be useful to see more description of how these activities might be linked with activities designed to ensure the longer term strength and sustainability of the immunisation system. For example, how are the maintenance costs for the transportation units acquired and the cold storage capacity to be maintained, replaced and sustained over time? What is the likely impact on, or relationship with, the organization of the immunisation delivery system?

8. Feasibility

The activities described are largely feasible. Objective 1 as proposed is extremely broad, very unclear and cannot be easily measured. In addition, there are major problems in the area of data quality and the stated intention to improve the availability of immunisation data tools and equipment for processing, analysing and transmitting data and the provision of "programme specific HIS management and operational research".

9. Soundness of the financing plan and its sustainability

There is a clear government commitment that may help to ensure sustainability. However, there needs to be some budgetary allowance for maintenance and replacement costs. This seems especially important in light of the stated problem with maintaining operating costs.

10. Added value

It is not difficult to see the added value of the activities proposed under Objectives 2 & 3. However, those under Objective 1 are largely an amalgam of a variety of activities ranging from training, advocacy, programme management, updating of training material and the acquisition of vehicles. It is not clear how these will significantly contribute to the longer term health system strengthening aims.

11. Consistency across proposal documents

There is good consistency across all the relevant supporting documents and the proposal.

12. Recommendation

Recommendation: Final approval requires further information.

HSFP IRC May 2012 review of response by Tanzania

1. The activities under Objective 1 need to be more focussed and streamlined to show how those planned can realistically be sustained in the longer term so as to significantly strengthen the HIS and to influence immunisation outcomes. Consideration should be given to removing some of the items from the programme of work.

Mostly Addressed: *This objective is still very broad and encompassing category where "other stuff" has been included. In this version Objective 1 is:-*

Improved immunization outcomes (coverage & quality) in the context of integrated

Health services – National wide.

The proposed activities fall into 4 broad areas:

- *Human resource development through training in management and leadership skills, knowledge and skills to undertake comprehensive supportive supervision, to provide mentorship and on job training, in for general programme management and use of information systems for decision making;*
- *Facilitating supportive supervision;*
- *The provision of transportation*
- *Improving the data system for immunization.*

Activities are now more coherently put together. There are also revised indicators for Objective 1 in line with proposed activities. However, a query may be raised about the inclusion of items (e) and (f) at a cost of \$376,823 and \$376,471, respectively – under this objective. The refurbishment of the EPI/MOH unit over a period of years does not seem to support the desired outcomes related to health system strengthening. It is also not clear why this needs to be stretched over three (3) years.

It is not clear why supportive supervision needs to be costed at \$1.80m. What types of activities are envisaged here? This needs to be clearly explained.

2. Following from the above, there needs to be more and better detail about how the proposed activities will address the need for "HIS management and operational research that is essential for programmes like EPI."

Partially addressed: The proposal does not really provide much detail on this matter. Instead, it seems to have now redefined the task and now restricts itself to the provision of data management tools and to performance review and monitoring. It also indicates the intention to “conduct operational research on vaccine management aiming to reduce vaccines wastage and increase efficiency”, and/or to “ensure that there is availability of reliable and quality immunisation data.” The activities that appear to be the ones that will now address this issue are the provision of training in the areas of management, and the recruitment of senior local consultants who will “work with the EPI Unit to build capacity of EPI staff on financial management under this platform, facilitate monitoring and evaluation of planned activities, and support EPI to conduct operational research.” There is a budget for operational research on vaccine management. TA will allow the EPI unit to be able to carry out “the day-to-day activities the EPI programme.” In this connection it would be useful for there to be a performance indicator for the provision of the TA. The current performance framework has the indicator for HSS Facility management as the “Number of implementation progress reports produced.” This is not useful; better indicators of performance of the consultants and their impact on EPI management are needed.

It has been noted that a HMIS is currently being piloted in one region. Some further detail on how and in what ways the proposed activities will be integrated into or related to that piloting would be useful.

3. More information is required about how the longer term operating costs (in light of the high capital investments to be made) are to be handled, and what will ensure the longer term sustainability.

Largely addressed: It is stated that since the Government is implementing decentralization by devolution; most of operational duties are devoted to councils. The procured vehicles by HSFP have been allocated initial maintenance cost for the first two years. Thereafter the maintenance of procured vehicles and cold chain equipment will be done and reflected in the Comprehensive Council Health Plan annually as it is for the other existing vehicles and cold chain equipment. Even so, it should be noted that in the budget HSFP procured vehicles carry maintenance costs for the life of the project: i.e. 4 years. It is advisable that the country not only establishes a facility for the maintenance of vehicles – but also one for their eventual replacement. The normal procedure is to establish a fund that is then placed in Escrow and into which a percentage [usually 20-22%] of the replacement cost of the vehicle is placed by the government. The write-off period is normally about 5 years.

With regard to the vehicles it might be useful to know where exactly these vehicles are to be assigned. In light of the earlier IRC recommendations, Tanzania has now reduced the number of vehicles to 60. It explains that there are 142 districts and that 121 had received vehicles from the Global Fund- HIV; and that the 60 vehicles will go to districts with no vehicle - particularly in the hard to reach areas. However, it does appear that all regions have already received GAVI vehicles. It may be further noted that according to the performance framework the number of districts considered hard to reach is 45 and not 60. Also, the 60 vehicles are in addition to the request for 40 motorbikes, 3,000 bicycles and 7 boats for the hard to reach areas. The MOH needs to justify the requirement for this high number of vehicles given that districts without a vehicle - according to their narrative - is 21. Given that

the procurement of transport inputs is 45% of the proposal, a clearer and more comprehensive explanation needs to be provided together with a rationale for allocation.

4. There needs to more careful attention on how the proposed activities will significantly affect the more structural and systemic problems (weak co-ordination mechanisms, the inability to meet recurrent costs and the declining expenditure on EPI, and the problems with the organisation of the delivery of services) identified in the proposal.

Not really addressed.

5. *Additional areas for clarification:*

- A) There is no clear description of how the private sector will be part of the described activities

It is stated that immunization service is provided free in both private and public facilities and government provides vaccine, and related supplies. In this proposal activities are implemented at district covers both private and public

Satisfactorily addressed

6. ***Some outstanding issues:***

- A) It is noted that the performance framework is for three years (2012-15) rather than for the whole life of the project (up to 2016).

- B) *Despite a number of donors supporting HSS such as WB, USG, CIDA, UNICEF and WHO (as mentioned in the proposal), in the HSFP supplemental funding attachment, only Global Fund R9 activities are considered. This does not provide a complete picture of what is being supported in Tanzania in HSS.*

Recommendation: Approval with Level II clarifications:

1. Please indicate how the proposed 60 vehicles will be allocated in the marginalised/hard to reach areas given that:
 - Global Fund has already provided 121 for the 142 districts
 - The performance framework considers 45 the number of hard to reach districts
 - The number of districts without a vehicle is 21
 - The transport allocation for the hard to read areas is 40 motorbikes, 3,000 bicycles and 7 boats.
 - The 60 vehicles are labeled 'distribution' in the budget
 - Confirm that the drivers required for the vehicles will have their salaries paid by the MOH.

A comprehensive explanation needs to be provided together with a rationale for allocation. In responding to this issue, the IRC would like to receive the inventory of transport, cold chain and other hardware that the EPI has to support the vehicle request.

The budget also needs to be corrected to show that maintenance costs will only be provided for the first two years.

2. The HSFP supplemental funding attachment is incomplete. Please reflect the programmatic relevant HSS activities of development partners such as WB, USG, CIDA, UNICEF and WHO (as mentioned in the proposal) since only Global Fund Round 9 is considered. Please provide fairly specific information on the types of activities. The use of general or global categories [such as “supporting human resource development”, or “strengthening health service delivery”] is not sufficient;
3. The period covered by the performance framework needs to be brought in line with the period for the proposal request;
4. Please provide further details and/or better justification of the need and budgetary expenditures for office refurbishment. This together with the proposed production of IEC activity needs to be better justified and logically integrated with the activities now under Objective 1. Otherwise their elimination should be considered.
5. Please provide more detailed information and better justification of the budget for Supervision;
6. Please provide more relevant and useful indicators of improvements in HSS facility management
7. Please provide more specific information on how these proposals for dealing immunisation data are to be integrated into the pilot HMIS now in progress;
8. With regard to the use of TA please provide a description of how the MOH will institutionalize the gains from the activities of the TA to ensure sustained improved capacity.

Recommendation: It is strongly recommended that the country consider the establishment of a funding mechanism e.g. an escrow account that would facilitate the eventual replacement of the vehicles being purchased.

IRC HSFP COUNTRY REPORT
Level II Clarifications, 27 August , 2012

Country name: Tanzania
Type of support requested: HSS
Application method:

Country profile/Basic data

Proposal duration	2013-2016
Budget required	US\$15,591,420
cMYP duration	2010-2015
National health strategy document included	
National Health Plan duration	2009-2015
Population (year)	45.3million [projected for 2011]
IMR	59 per 100 l.b.
DTP3 coverage (country/UNICEF)	91%

IRC Recommendation	Tanzania has satisfactorily addressed three (3) of the eight (8) clarifications requested by the IRC. These are Clarifications No. 1, 3, & 7. Clarifications No. 2 & 8 have been partially satisfied. Further clarifications are requested for the remaining 4 clarifications identified by the IRC. In addition, the IRC recognises the continuing weaknesses in countries in the area of performance framework development. It is therefore highly recommended that GAVI and its partners seek to provide maximum TA to Tanzania as it refines its PF. Finally, the budget needs clearer and more specific details. It is also recommended that the GAVI Secretariat provides close
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	scrutiny of the budgetary details [including the unit costs and their justifications] provided.
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Major and Minor Weaknesses identified by the IRC

The country has made a great effort to provide the details and information requested by the IRC. It has provided most of the supplemental funding [i.e. for HSS activities] information, and has adjusted the budget to show greater country contribution in the maintenance of the transportation. It has also generally described the need for and importance of supportive supervision. The performance framework has been brought in line with the period of the proposal request.

The weaknesses are identified for each clarification request and the country's response

Major Weakness 1

Clarification # 4: Please provide further details and/or better justification of the need and budgetary expenditures for office refurbishment. This together with the proposed production of IEC activity needs to be better justified and logically integrated with the activities now under Objective 1. Otherwise their elimination should be considered.

IRC Response: The budget for these activities continues to be somewhat confusing. In the Budget Overview the budgetary allocation for "Rehabilitation and equipping national office" is US\$94,118 for one (1) office. However the budget details show US\$58,824 for 1 office each year. The total cost would then be \$235,296. However, in the same sheet the total cost over 5 years is \$376,471. Further to this, the proposal wishes to improve Two (2) Zonal vaccine Stores at a unit cost of US\$58,824. This would result in a total cost of US\$117,648 for the period. However, US\$176,471 has been allocated to Zonal Vaccine Stores; it would therefore also appear that three (3) Zonal Stores are to be improved at a total cost of US\$176,471. At the same time, in the performance framework it is stated that there are 5 'units' - called the EPI National office and zonal stores - that are to be rehabilitated. This needs to be clarified and the budget lines matched, fully justified, (particularly as in the proposal narrative there is no justification for new vaccine stores in 'new zones') and brought in line with the proposal's text and the performance framework.

Major Weakness 2.

Clarification # 5: Please provide more detailed information and better justification of the budget for Supervision

IRC Response: The budgetary allocations for supervision, the proposed plans for the actual conduct of supervision and the way progress is to be measured are unclear. The plan of work and the budget states that supervisory visits are to occur in all the targeted districts for each year. However, the performance framework suggests that 100% coverage will not be achieved until the end of the funding – i.e. Year 3. Question: is it that the conduct and expansion of supervision will occur on an incremental basis? And that full coverage of the 142 districts will therefore not be achieved until Year 3? In the budget the Unit of analysis is the district. It would appear that a total of 60 districts are to be targeted and covered in the 3 year period [and not 60 per year]. If this is the case then 60 [and not 142, as is the case in the Performance framework] ought to be the denominator. This would then alter the targeted percentages used in the PF.

More important however, is the question of what this activity entails and therefore also what precisely is being budgeted for. In the text of the proposal it is implied that supervision will be improved and implemented through training [i.e. the provision of “knowledge and skills to undertake comprehensive supportive supervision] and visits from Region to district level, and from District level to facility level. In the text of the revised proposal there is the suggestion that those individuals who have now acquired “supervision competence” will seek to “establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service.” However, it is not clear what is being costed. The cost of training? The conduct of on-the-job trainings? But are these costs not already covered under SDA 1.1? Transportation costs? If so, are these additional to the funds already allocated to the procurement of vehicles? The Assumptions Sheet of the Budget shows that almost all items under SDA1.1 have budgetary allocations for DSA, fuel and travel. What does “travel” [for almost US\$23,000] cover that is not already covered? More specifically, the Assumption Sheet shows that US\$5,056 will cover DSA, travel, fuel and the compilation of micro-planning packages at the district levels. Yet, the Detailed Budget shows that a total of US\$1,801,553 is to be spent on Supervision [Activities 1.2a & 1.2b] over the entire period. What explains this difference?

The response has given good reasons why supervision is generally a good idea. It has also given a broad description of the kinds of activities that are to be carried out during the supervision visits. But since the Unit costs given are in relation to the number of districts and facilities it is difficult to find the description, justification and costs for the specific activities to be carried out. Also, How is “supervision competence” to be measured? What is to be the function of the District Health Management Teams (DHMT) which was supposed to have some sort of integrated supervisory role? Are there any plans for integrated district level visits which would reduce the transportation costs?

Not clarified. This section needs to be revisited – with the roles, functions and appropriate costings more clearly specified and justified. Unit costs need to be clear and appropriate and apparent double counting of transportation and supervision costs eliminated.

Major Weakness 3

Clarification # 6: Please provide more relevant and useful indicators of improvements in HSS facility management

IRC Response: Although these indicators attempt to address and measure HSS activities it needs to be recognised that they may assume, but

do not necessarily measure improvements in facility management. In other words, the expectation that “Timely and complete reporting is primarily depending on managerial effectiveness” is likely to be a faulty one. The production of a report may have little to do with managerial effectiveness; there is likely to be a range of other influential factors [such as infrastructural, information and human resources]. The mere production of reports may therefore not be an adequate measure. Further, low drop-out rates and high coverage levels may not at all be related to improvements in facility management and does not say what have been the changes in facility management that may have contributed to these outcomes. It is therefore hard to see “what worked.” It is important to be able to see and track the relationships between changes and improvements in facility management strategies, changes in the quantity and the quality of the services offered by the facility and improvements in immunisation coverage. The development of the indicators here will need to have a baseline.

It is recognized that the design and development of appropriate performance frameworks has been and continues to be a difficult area for many countries. Those relating to HSS need to be more meaningful showing how the proposed activities will strengthen health system capacity and how this in turn will contribute to improved immunization outcomes. The IRC also recommends that GAVI and its partners work very closely with Tanzania to strengthen this segment of the proposal and its PF.

Clarification # 8: With regard to the use of TA please provide a description of how the MOH will institutionalize the gains from the activities of the TA to ensure sustained improved capacity.

IRC Response: The country’s response is only partially satisfactory as it only focuses attention on what the consultant will do; there needs to be more specific indications of ‘how’ the improved capacity is to be sustained. In other words, in the specific context of Tanzania how exactly will the MOH institutionalise the gains from the activities of the TA? Are there any specific strategies for ensuring the transfer of knowledge and skills and of measuring progress in this area?

Clarification # 2: The HSFP supplemental funding attachment is incomplete. Please reflect the programmatic relevant HSS activities of development partners such as WB, USG, CIDA, UNICEF and WHO (as mentioned in the proposal) since only Global Fund Round 9 is considered. Please provide fairly specific information on the types of activities. The use of general or global categories [such as “supporting human resource development”, or “strengthening health service delivery”] is not sufficient.

IRC Response: This clarification has been partially satisfied. Although there may be no “final programme description used by the Global

Fund” in the actual Grant Agreement, it may be assumed that there is a work plan for HSS activities that is associated with the R9 grant – both in existing GF documents and in the documents used by the implementers. Please provide copies of these (other than the R9 budget already received) so that there can be a clearer understanding of what is being funded.

Applicant’s Response 1:

Date: dd- MM-yy

Supporting Documentation from the applicant relevant to the response

Annex 1 –

IRC Comments and/or request for further clarifications 1:

(indicate whether the IRC is satisfied with the clarifications/adjustments provided (with or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)

The IRC is satisfied with only 3 of the country’s responses; it is partially satisfied with two, but remains dissatisfied with the remaining three. The country needs to respond to the issues and questions raised above.

Date: dd- MM-yy

APPENDIX D

GAVI Alliance Terms and Conditions

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THIS PROPOSAL

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US\$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US \$100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

USE OF COMMERCIAL BANK ACCOUNTS

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.