



Report to the GAVI Alliance Board

7-8 July 2011

Subject:	Cash Based Support
Report of:	Nina Schwalbe, MD, Policy and Performance
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Agenda item:	08
Category:	For Decision
Strategic goal:	SG2 - Health systems to deliver immunisation

Section A: Overview

1. Purpose of the report

- 1.1 The purpose of this report is to seek endorsement of the GAVI Alliance Board for the Programme and Policy Committee (PPC) recommendations as described below including the bridging mechanisms for HSS, ISS and CSOs proposed in this report.

2. Recommendations

- 2.1 It is recommended that the GAVI Alliance Board adopt the following resolution:

The GAVI Alliance Board resolved to:

Request the Secretariat to continue working with partners to rollout the Health Systems Funding Platform (the "Platform") in a manner which ensures that the immunisation outcomes are clearly articulated in accordance with country demand, including assessing and addressing associated risks;

Request the Secretariat to develop options for performance incentives for GAVI's cash based support through the Platform in coordination with the design of the Incentives for Routine Immunisation Strengthening (IRIS) pilot;

Request countries and their partners to carry out an analysis to establish the main reasons why countries have DTP3 coverage rates below 70 percent; why some countries have coverage rates stagnating at low level; and why some countries have seen significant declines in coverage over time. The aim of this

analysis is to inform the design of targeted and enhanced support to this group of countries to improve coverage;

Request the Secretariat to develop options for ensuring co-ordination, accountability and good communication for SG2 programmes.

Endorse the bridging mechanism for Immunisation Services Support (ISS) set out in Annex 2 to the report to the Board on Cash Based Support, Doc 08;

Approve an amount of US\$ 7,214,100 for extensions for countries already receiving "Type B" support for civil society organizations (the "Type B Support Amount") and delegate to the Secretariat the authority to approve such extensions up to the Type B Support Amount in accordance with the process set out in Annex 3 to the report to the Board on Cash Based Support, Doc 08;

Request the Secretariat, following the completion of the evaluation of CSO support in 2011, to review options for direct support to CSOs for service delivery and advocacy and submit to the PPC for its recommendation to the Board. In the meantime, systematically promote CSO engagement through the Platform in those countries due to receive all forms of GAVI support;" and

Endorse the transitioning arrangements from existing GAVI Health Systems Strengthening (HSS) support to the Platform as set out in Annex 4 to the report to the Board on Cash Based Support, Doc 08.

3. Executive summary

- 3.1 This report summarizes the recommendations of the PPC based on the work of the Cash Based Task Team on the future of GAVI Cash Based support.
- 3.2 Based on the recommendation of the PPC, it is recommended that GAVI bring together its cash based support into one support window under the Health Systems Funding Platform.
- 3.3 The report explains the PPC recommendations on the proposed role out of the Health Systems Funding Platform and bridging mechanisms to be put in place to ensure availability of funds for countries facing a financial gap until they can access funding through the Health Systems Funding Platform and the risks and risk mitigation related to the proposed actions.
- 3.4 Based on the recommendations by the Cash Based Task Team to the PPC the report also presents measures to address trends of low and declining DTP3 coverage rates.

- 3.5 The Task Team working on India and Nigeria may propose recommendations on cash-based support for these countries to the PPC in September 2011.

4. Context

- 4.1 At its meeting in November 2010, the GAVI Alliance Board requested the PPC to provide it with “a comprehensive approach on cash-based support to countries including a strategy for countries that are below 70% DTP3 coverage or have stagnating or declining coverage.”¹

- 4.2 In response to this request the PPC set up a Task Team chaired by Paul Fife in January 2011. The Task Team also reviewed the Board requests to focus on countries screened out from new vaccines because of their low DTP3 coverage, to ensure that GAVI funding through cash based programmes is designed to have a reasonable and demonstrable impact on immunisation programmes in the context of integrated service delivery, and that immunisation coverage is a credible outcome indicator for these activities. Finally, the Task Team reviewed the Secretariat plans regarding evaluation of HSS investments.

- 4.3 To date, GAVI has provided cash based support through three windows: health system strengthening (HSS), civil society support (CSO types A and B) and performance based funding for immunisation support (ISS). Through business plan funding for WHO and UNICEF, GAVI also provides technical assistance to countries to help them improve their coverage.

- 4.4 The GAVI Alliance Strategy 2011-2015 also aims to contribute to strengthening the capacity of integrated health systems to deliver immunisation (SG2 Contribute to strengthening the capacity of integrated health systems to deliver immunisation). Within this goal, GAVI’s objectives are to: contribute to strengthening the capacity of integrated health systems to deliver immunisation by resolving systems constraints; increase equity in access to services and strengthen civil society engagement in the health sector.

- 4.5 Although the current windows have played complementary roles, there are significant efficiencies to be gained, primarily at country level, by ensuring that GAVI’s cash based support is comprehensive rather than provided under separate windows. For this reason, it is envisaged that the Platform will become GAVI’s vehicle for cash based support. The current state of the implementation of the Platform indicates that by 2014 GAVI can support immunisation systems to all eligible countries through investment in their national health strategies.²

¹ GAVI Alliance Board Meeting of 30 November and 1 December 2010, Final Minutes, Resolution Eight.

² For fragile or high risk countries, GAVI and partners may need to adopt a modified investment strategy with support to more “project type” investments and related controls. This approach is currently under discussion.

- 4.6 By providing funding on the basis of national health strategies, the GAVI Alliance can help ensure that immunisation is a critical component of health systems. The Joint Assessment of National Strategies tool (JANS), combined with GAVI's engagement will ensure that immunisation objectives are included in national health strategies and that immunisation related indicators will be included in the joint evaluation framework. Countries receiving GAVI support will report on these indicators on an annual basis – and their progress will be assessed accordingly.
- 4.7 The PPC agreed with the Task Team that GAVI cash based grants under the HSFP must have a clear link to immunisation outcomes. The PPC also considered that there must be a balance between requiring attribution for every dollar spent and increased transaction costs for countries to report back. GAVI investment in national health strategies is primarily a contribution to immunisation outcomes and while immunisation outcomes are tracked regularly in all countries it is not possible to attribute changes in such outcomes specifically and exclusively to GAVI dollars. It is recognised that a large number of other investments and strengthening actions – primarily those taken by countries themselves – influence immunisation outcomes.
- 4.8 The current GAVI cash-based support to a number of countries will end in the years 2011, 2012 and 2013, prior to revision of their national health strategies and the full implementation of the Platform. In order to facilitate countries' transition to support of their national health strategies under the Platform and bridge any potential financial gaps in the support to countries interim solutions are proposed. The following bridging methods are recommended for endorsement by the Board:
- (a) **ISS:** ISS would be extended for eligible countries until they can access new funding through support of their national health strategies under the Platform. Countries will be rewarded based on additional children being vaccinated with three doses of DTP-containing vaccine, using the existing ISS reward criteria. The financial impact of extending ISS to all GAVI eligible countries for the period until the end of 2014 is expected to amount to a maximum of US\$ 31.5 million.³ See Annex 2 for more details, including eligibility criteria. This amount is included in the financial forecast for cash based support based on the revised policy of 15-25% of total programme support to be spent on cash based support between 2011 and 2015.
 - (b) **CSO:** Subject to Audit and Finance Committee (AFC) review, the PPC in March 2011 recommended extending Type B support for civil society organisations in eligible pilot countries for up to 12 months.⁴ In May the AFC reviewed the financial implications of extending Type B support for those countries already in receipt of Type B CSO funding and confirmed that an amount of up to US\$ 7,214,100 would be available pending

³ This amount is included in the expected balance of demand for Cash Based Programmes as estimated by the Secretariat and presented to the AFC.

⁴ At its meeting in March, the PPC recommended that extensions for Type B support would be for up to 12 months. In May 2011, the PPC requested that funding for a bridging mechanism, including for CSO support, be available until eligible countries can access such funding through the Platform.

approval by the Board. The PPC also requested that GAVI systematically promote CSO engagement through the Platform in those countries due to receive all forms of GAVI support. It is possible that some countries may seek funding for CSOs as part of a Platform application instead of requesting an extension to Type B. However it is also possible that some countries are not able to apply for the Platform before the 12 month extension period is complete and may require further extension. It is thus proposed that the Board approve an amount of up to US\$ 7,214,100 for country applications for extensions to be approved under the process set out in Annex 3 of this report.

- (c) **HSS:** The implementation of the Health Systems Funding Platform requires transitioning arrangements to ensure ongoing support to countries not yet ready to apply based on their national health strategies. A Common Application Form and process, developed together with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and WHO, will be used for countries that are not yet able to apply on the basis of their national health strategy to continue to access support for health systems strengthening activities. The transition arrangement will come into effect in August 2011 and end in 2015. It is expected that between 8 and 12 countries will use the common application process during this period. After 2015 all countries should access GAVI cash support using the Request Template in support of their National Health Strategy, except for a small group of fragile countries that may need this provision for a longer period.

- 4.9 In support of implementation of the Platform, a number of joint tools and guidance documents have been developed through the cross-agency monitoring and evaluation (M&E) working group led by WHO. Further, an interagency Task Team, led by the GAVI Secretariat, has been formed to redesign the data quality audit tool (DQA) to help strengthen national reporting systems. A pilot of the revised DQA will be completed by the end of 2011.
- 4.10 Based on the recommendations from the Cash Based Task Team, the Programme and Policy Committee recommended that investments in national strategies through the Platform should be contingent on performance but that such an approach would have to take into account the need for predictable funding and limit the award share to a reasonable level. As such, the Task Team requested that the IRIS Task Team put forward performance based financing options for the joint funding of national strategies.
- 4.11 With regard to countries with DTP3 coverage below 70% and low coverage countries with declining or stagnating coverage (see Annex 5), the PPC acknowledged the need for additional analytical work to establish reasons for such low or declining coverage. Such an analysis should involve GAVI Alliance partners (WHO and UNICEF) working closely with country counterparts and particularly involve civil society organisations. The analysis should discuss possible triggers for action and inform the development of multi-partner strategies in country. These strategies should be coordinated with other immunisation related activities (e.g. measles, polio) and may require enhanced

advocacy and technical assistance. As part of this work, the PPC asked for defined parameters for how to assess some of the core functions of the system for this group of countries and the need for a closer collaboration between immunisation and health systems experts with regard to both implementation and technical assistance.

- 4.12 In early 2012, the Secretariat, under the guidance of the Board's Evaluation Advisory Committee will conduct an evaluation of the original GAVI investments in HSS to date to better understand what was achieved and what are the lessons learned. This will aim to build upon rather than duplicate work already done in the 2009 HSS Evaluation and the Second GAVI Evaluation and will include an evaluation of the early experience with the Platform to inform its further design and management. Moving forward, GAVI's prospective evaluation efforts and routine programme monitoring will aim to capture programme effects and, eventually, impact.⁵

5. Next steps

- 5.1 The eventual model for GAVI cash based grants is support of national health strategies through the Health Systems Funding Platform. Until countries can access support for their national health strategies, bridging mechanisms, as outlined above, will be put in place with the aim of transitioning countries into support through the platform. For additional detail, please see annexes 2-4 to this report.

6. Conclusions

- 6.1 Through a comprehensive approach to GAVI Cash Based Support efficiencies are gained and transaction costs can be reduced especially at country level. By transitioning countries into support of national health strategies GAVI is also ensuring commitment to the Paris principles and the IHP+ agenda.

Section B: Implications

7. Impact on countries

- 7.1 A comprehensive approach to GAVI cash based support through the platform will reduce transaction costs for countries in the long term by reducing the number of grants and providing flexible support focusing on outcomes and less on inputs. Platform partners will use a common application process, reporting framework for follow up and common fiduciary arrangements for monitoring and assessment of financial risks. There will be opportunities for common

⁵ As part of the 2011-2015 strategy, targets and indicators have been developed for GAVI's work on strategic goal 2. These can be accessed on the GAVI website http://www.gavialliance.org/resources/Strategy_2011_2015_Table.pdf

assessments of in-country institutional arrangements to reduce the number of missions to countries.

8. Impact on the Business Plan / Budget / Programme Financing

- 8.1 Additional analytical work or technical assistance provided by WHO and UNICEF (or others) might require reprogramming of planned activities in 2011 and potentially additional resources in 2012.
- 8.2 It is not expected that the proposed bridging methods including an extension of ISS will have financial implications beyond the estimated balance of demand for the period 2011-2015 for cash based programmes.

9. Risk implications and mitigations

- 9.1 The overall risk implications for GAVI and the mitigation strategies are divided into four main categories: financial, operating, country sustainability, personnel/organisation.⁶
- 9.2 Financial risk relates primarily to the possibility that funds could be misused. The mitigation strategy includes implementation of the GAVI transparency and accountability (TAP) policy. With regards to jointly financed programmes through the Platform, any such risks may be further mitigated through joint (fiduciary) oversight with other development partners and joint remedial action in case of misuse. Improved harmonisation with other donors and alignment with country procedures including use of commonly agreed monitoring and fiduciary frameworks will ultimately decrease risk related to misuse of funds and increase opportunities to track performance. This could lead to improved confidence among donors and reduced perceived risks in relation to investments in GAVI. This risk is currently assessed as medium.
- 9.3 Operating risks are those that most affect countries, for example fund flows and delays in disbursements. As with current GAVI HSS support, these risks are assessed as medium to high. However pooling funding and jointly financing the national health strategy with government and other development partners can help decrease these risks by decreasing dependence on any one donor. This risk is currently assessed as medium.
- 9.4 Country sustainability risks relate to service delivery at country level. The Platform carries a risk of stretching the already limited capacity of countries to carry out JANS processes. The risk mitigation strategy includes actively working with countries ready for a JANS process and working closely with WHO and other partners to initiate the process. This risk is currently assessed as low.

⁶ These risk categories are based on GAVI risk matrix as presented to the Board in November 2010.

- 9.5 Personnel/organization risk relates to the Secretariat and partners capacity to deliver on the business plan. A mitigation strategy is to look at skills and headcount within the Secretariat and to work closely with Alliance and Platform partners to share the burden of work within a coordinated framework/plan. This risk is currently assessed as high.
- 9.6 In addition to these overarching risks, there are some programme specific risks for ISS.
- (a) With regard to risk for countries, there is a risk of low utilisation rates of ISS funds by countries. A mitigation strategy is to ask countries for a plan as to how the reward is intended to be spent prior to distribution of funds.
- (b) With regard to risk for GAVI, extending ISS may expose GAVI to reputational risk as the programme has been criticized in the academic literature. However, the recent independent evaluation of GAVI's second phase conducted by CEPA concludes that the programme is successful for countries with DTP3 coverage between 65 and 80% DTP3. Thus, overall, the risks around an extension of ISS are assessed as "low."

10. Legal implications

- 10.1 At present, further to the GAVI Alliance Transparency and Accountability Policy and following a financial management assessment GAVI negotiates an aide memoire with a country that set outs the agreement reached on financial management arrangements of GAVI's cash based support in that country. Where a joint financing mechanism is used for GAVI cash based support in a country, GAVI needs to agree on the arrangements with partners participating in the joint financing mechanism and/or the country. Similarly, with the implementation of support to national health strategies, GAVI will also likely be a signatory of joint financing agreements with development partners and/or countries.
- 10.2 The Secretariat is currently reviewing its grant arrangements with countries, including for cash based support, with the dual aims of simplifying and harmonizing those legal arrangements and minimizing fiduciary risks to GAVI funding.

11. Consultation

- 11.1 This report was developed in consultation with and under the guidance of the GAVI Alliance Cash Based Support Task Team. The Task Team brings together a wide group of stakeholders including PPC members, CSO representatives, representatives from implementing countries, as well as other Alliance Partners (annex 1).

12. Gender equality implications

- 12.1 In 2009-2010 the GAVI Alliance supported WHO to conduct an analysis of gender related barriers to immunisation which was presented to SAGE in 2010. The study showed that although coverage is relatively equal in most countries between boys and girls, other gender related issues do affect access to services. Examples of this are the gender roles of women and men in the family and in the community and that the gender of health providers can create barriers for the immunization coverage of all children.
- 12.2 Based on findings from the study, the GAVI Secretariat will prepare a guidance to help countries and platform partners identify gender related barriers and develop appropriate gender sensitive interventions that can be implemented in the context of their national health strategies.

13. Implications for the Secretariat

- 13.1 A comprehensive approach to GAVI cash based programmes should in the long term reduce the administrative load on the Secretariat of these programmes. In the short term additional administrative load will be put on the Secretariat for regular dialogue with Platform partners as the policy parameters and processes are worked through, including development of new application forms and review processes.
- 13.2 The Platform will also provide an opportunity to draw upon Platform partners for assessments and reviews, such as FMAs, JANS missions and Annual Progress Reviews of national health strategies.
- 13.3 An increased focus on low performing countries and the application of results-based financing schemes may require additional resources for the Secretariat for implementation and follow up.
- 13.4 Funding of national health strategies will require a change in approach from a Geneva based review of annual progress reports to an exercise primarily conducted at country level during the annual health sector review. Participation by GAVI will require additional resources. If country level review of national health strategies and annual progress result in funding recommendations to the Board, this may have an impact on GAVI's operating model in that currently the Independent Review Committee ensures the independence of recommendations for approval of funding. Options for such country level reviews are currently being developed by the Secretariat.

ANNEX 1 Terms of Reference for GAVI Alliance Task Team

Time Limited Task Team for Review of Cash Based Support
Duration: February 2010 – May 2011
Chair: Paul Fife, Norad, PPC and Board member
Reporting to: Gustavo Gonzalez, PPC Chair and Board member
Terms of reference approved on: 19 January 2011

Scope: The task team will develop a comprehensive and cohesive approach to GAVI Alliance funded cash based support programmes to countries. The report will address how these programmes support GAVI's core mission and strategic goals, including how they support countries that are below 70% DPT3 coverage, or have stagnating or declining coverage with options and recommendations. It will also address the role of the programme to develop incentives for routine immunization strengthening (IRIS).

Background/Context: In December 2010, the GAVI Board discussed the range of GAVI's cash based programs – including health systems strengthening and the new common platform, incentives for routine immunisation strengthening (IRIS), immunisation services strengthening (ISS), support to civil society and country introduction grants. As a result of this discussion, the Board felt greater clarity was needed on how these programs fit together and support GAVI's core mission and strategic goals to ensure that GAVI's approach in HSS and with regard to countries with low coverage was comprehensive in nature.

Deliverables: A report for presentation to the PPC in September. This report will form the basis for a PPC recommendation to the Board in December 2011.

Reporting lines: The task team reports to the Chair of the PPC

Membership: 7-9 constituency representatives. Representative members to be proposed by the PPC and confirmed by the chair, taking into account the need to achieve a gender balance and include diverse geographical representation.⁷

- Paul Fife (Board and PPC member, Norway, UK, Ireland) - chair
- Lola Dare (independent expert, Nigeria)
- Mekdim Enkossa (EPI programme, Ethiopia)
- Lidija Kamara (WHO/IVB) - alternate: Patrick Kadama (WHO/EIP)
- Paul Kelly (GAVI Secretariat) - alternate: Mercy Ahun (GAVI Secretariat)
- Marwin Meier (World Vision, Germany) - alternate: Julia Hill (MSF International, Geneva)
- Violaine Mitchell (Gates Foundation, USA)
- Albertus (Bert) Voetberg (World Bank, Nepal)
- Julia Watson (DFID)

⁷ Note that at some meetings, members were represented by alternates listed above

Relationship with the GAVI Business Plan

Relevant strategic goals/objectives: This activity supports the achievement of GAVI's mission focusing on the implementation of strategic goal 2 – strengthening the capacity of integrated health systems to deliver immunisation.

Annex 2: Bridging mechanism for ISS

Countries that meet all of the following criteria are eligible for ISS bridge support:

- Countries with <\$1500 GNI per capita, as adjusted for inflation;
- Countries which have participated in ISS previously;
- Countries that cannot yet access HSFP funding; and
- Countries which are not part of the Large Country Strategy.

ISS rewards are only available:

- Until the year the country can apply for HSFP funding.

ISS bridge support will consist of reward phase support only. Countries eligible for ISS bridge support will be reviewed through the usual Independent Review Committee mechanism. The Independent Review Committee will make recommendations for reward payments to the GAVI Alliance Board for countries that meet the previously developed reward criteria.⁸ For countries eligible for ISS bridge support, the 2010 performance will be compared against the highest number of children vaccinated with three doses of DTP-containing vaccine⁹ that GAVI paid against during the country's earlier participation in ISS. This is consistent with the payment rules for ISS phase 2 support. The same process would be followed until the year that countries can apply for HSFP funding.

Prior to the first disbursement of ISS funding under this bridge mechanism, countries would be required to submit a plan for how they plan to spend the monies provided by GAVI.

It is estimated that 1.5 million additional children will receive three doses of DTP-containing vaccine in countries during the time that they qualify for ISS bridge support, which would translate into US\$ 31.5 million in reward payments.

⁸ These requirements are: vaccinating more children with 3 doses of DTP-containing vaccine than the previous high and having administrative coverage that is not more than 5 percentage points higher than the WHO/UNICEF coverage estimate. In cases where administrative coverage is more than 5 percentage points higher than the WHO/UNICEF coverage estimate, the Independent Review Committee assesses whether the discrepancy between administrative coverage and the WHO/UNICEF estimate is plausibly explained by uncertainty in the denominator. In such cases, the Independent Review Committee may put forward a recommendation for paying the reward, with justification.

⁹ Or the original target, in cases where the country never vaccinated more than the target number of children that GAVI paid against during the ISS investment phase.

Annex 3: Bridging mechanism for CSO support

The GAVI CSO pilot of Type A and B support was a time-limited programme. Most activities funded under Type B will conclude between end 2011 and mid 2012.

Qualifying countries¹⁰ can apply for an initial extension period of up to 12 months in accordance with the process below. A small number of countries may need a further extension, and the IRC will have the flexibility to recommend a longer time frame, provided the overall envelope of funding does not exceed US\$7,214,100.

Four months in advance of the expected completion of the funded activities a country will submit a request to the GAVI Alliance Secretariat for an extension of Type B activities. The request as endorsed by the HSCC/ICC should include a brief report outlining: progress towards achieving the objectives of the original Type B proposal; objectives and detail of the activities to be undertaken during the extension period; the requested amount and a breakdown of the estimated costs. The requested amount shall not exceed the amount of support the country received for the final 12 months of the current Type B support.

The Independent Review Committee (IRC) will assess the request for extension at its next available session or, if necessary, at a virtual IRC session. In accordance with the IRC recommendations and provided the total amount of approved extensions does not exceed US\$ 7,214,100, the Secretariat shall approve extension requests.

The Secretariat shall report on approved Type B extension request(s) to the Executive Committee.

Annex 4: Transition arrangements from existing GAVI HSS support to the Platform.

In order to transition countries into support from the Health Systems Funding Platform a common application process (the “Common Form”) with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) will be put in place. The process for application and review of application using the common form will be set out in guidelines accompanying that form. Countries which meet the following criteria are eligible to apply for HSS support using the Common Form:

- Below the GNI threshold for eligibility at time of application (<\$1500 GNI per capita, as adjusted for inflation);
- Current HSS support has ended but the national health plan has not yet been reviewed, with gap of greater than one year between the end of current HSS support and access to funds under the; and
- Not receiving support through the Platform.

¹⁰ Afghanistan, Burundi, DR Congo, Ethiopia, Ghana, Pakistan

Annex 5

Table 1: List of countries with below 70% coverage or declining coverage.¹¹

Countries with low or stagnating coverage (n=18)	DTP 3 coverage per WHO/UNICEF estimates	Percentage point change between 2005 and 2009
Lesotho	83	-4%
Zambia	81	-1%
Madagascar	78	-4%
Kenya	75	-1%
Mali	74	-3%
Guinea-Bissau	68	0%
Yemen	66	+1%
Liberia	64	+4%
Uganda	64	0%
Mauritania	64	-7%
PNG	64	+3%
Haiti	59	0%
Lao PDR	57	+8%
Guinea	57	-2%
CAR	54	0%
Gabon	45	0%
Somalia	31	-4%
Chad	23	0%

Source: WHO¹²

¹¹ The list is revised on an annual basis and countries may be subject to change. Countries with declining coverage but coverage that is still $\geq 90\%$ are not included (Uzbekistan and Kyrgyzstan), given their high coverage levels. India and Nigeria not included due to specific work undertaken through Large Country Task Team.

¹² http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tswucoveredtp3.htm