

## FOR DECISION

The November 2009 GAVI Alliance Board made a number of decisions related to the Health Systems Funding platform. The Board requested the PPC to report by April 2010 on plans to operationalise, pilot, monitor and learn lessons about the Platform. PPC was also to report on the transition to the Platform and the Platform's contribution to GAVI's objectives. This paper describes collaborative work on the Platform undertaken since November 2009 and responds to the Board's decisions and subsequent PPC guidance. The focus of this initiative is at the country level, but there has been some necessary global level joint working to develop a shared action plan in several key areas. As requested, this paper has the same overall structure as the equivalent GFATM paper.

The full proposed Decision Point is in Part 5 of this paper. In summary, the PPC recommends that the Board:

- Affirms the importance of GAVI support for health systems to improve service delivery outcomes and hence promote MDGs 4, 5 and 6, including in relation to vaccine-preventable diseases
- Requests the Secretariat to continue collaborative work on "Track 1" Platform countries – harmonising existing investments to ensure better health outcomes.
- Requests the Secretariat to continue work at national and global levels on the implementation of "Track 2, Option 1" of the Platform - a joint proposal form (to be approved by the PPC) with GFATM. Funding proposals would be subject to IRC review and Board approval.
- Requests the Secretariat to continue work in 4 to 5 countries on "Track 2, Option 2" - funding based on formally assessed National Health Plans.
- Requests the Secretariat to increase dialogue with countries and other partners and develop a communications strategy jointly with the World Bank, GFATM and others.
- Continue work to ensure the Platform is independently evaluated in 2012.

The budget for funding HSS depends on country requests. Proposals on staffing will come as a package with other requests at the June Board.

## Health Systems Funding Platform<sup>1</sup>

### Summary

This paper describes work undertaken since November 2009 to describe the operational, financial and policy implications of implementing a Health Systems Funding Platform. The paper responds to guidance from the PPC in its various meetings in 2009, its most recent telephone conference meeting on

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<sup>1</sup> This paper will refer to a number of supporting annexes that are available to any board member upon request. If you would like to receive an electronic copy of the annexes, please email Kevin Klock at [kklock@gavialliance.org](mailto:kklock@gavialliance.org).

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29 March 2010 and the decisions made by the Board in November 2009<sup>2</sup>. It also outlines a suggested decision point for the Board.

As requested, this paper mirrors the structure and content of the paper on the same subject prepared for the Policy and Strategy Committee (PSC) of the Global Fund, which met on 15-16 March, and will form the basis of the paper going to the GFATM Board on 28 April. However, all parts have been necessarily adapted to ensure that the concerns of the PPC and GAVI Alliance Board are addressed.

The Health Systems Funding Platform is important for two main reasons:

- As a platform for the health MDGs – investments in health systems directly lead to outcomes in relation to child health, including immunisation (MDG 4), maternal health (MDG 5), where least progress is being made, and HIV/AIDS, TB and malaria (MDG 6) which are all constrained by the quality of the underlying health system. Inevitably health systems investments also impact on other services.
- Current support is fragmented – high transaction costs mean less effective aid and hence less impact on health status.

This paper builds on the findings of consultations at country level with governments and other partners, including CSOs, global-level consultations with partners (including CSOs, bilaterals, UN agencies and others), and on-going discussion with the Global Fund, the World Bank and WHO. The four agencies have a joint workplan which is guiding the design and development of the Platform. This has been developed to take account of the relative strengths of each agency. The intent of the workplan is to ensure that better health outcomes (including for vaccine-preventable diseases, for responding to the particular challenges around MDG 5 etc.) results from support provided in a more streamlined and effective manner. It is also informed by the ongoing discussions around the new GAVI strategy development.

What is the Platform? The Platform would be based on three key elements at country level which GAVI, the Global Fund and the World Bank (and others) would support. These elements are fully consistent with Paris and Accra principles, build on IHP+ principles, and will use IHP+ tools, if the country so requests:

- **One national health plan or health systems strengthening proposal**, developed in an inclusive process with full multi-stakeholder engagement. This will outline *one framework for technical support* for the technical and managerial support for implementation of the plan at country level. The IHP+ Joint Assessment of National Strategies (JANS) tool could be used if requested, though other appraisal/assessment mechanisms can also be used.

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<sup>2</sup> See pgs 6 and 7 of this document which outlines the Nov Board decision point

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- **One financial management and procurement arrangement** with harmonised fiduciary oversight and one shared audit. A joint financing framework could be used at country level by GAVI, and other partners. This does not necessarily imply a pooled financing arrangement (though this is a possibility for those who can) and the joint framework could have the effect of leveraging additional funding.
- **One performance framework** which consists of one shared reporting format aligned with national cycles (for example, an annual report linked to joint annual reviews, and longer-term periodic reviews) and one M and E system with shared indicators to ascertain the benefits and impact to ascertain the benefits and impact of HSS support on MDGs 4, 5 and 6. The common monitoring framework developed under IHP+ could be used.

These three elements mirror the language used in global and national contexts when discussing how the Paris principles and IHP+ principles objectives can be operationalised. However another major issue is also emerging – the need for one technical support framework.

What the Platform is not: The Platform is not a new fund - it is about effectiveness and value for money for better health outcomes. It will enable countries to receive existing types of support in a more harmonised and aligned way, as recommended by the Paris and Accra principles for aid effectiveness.

The paper describes the two tracks that would form the basis of the Platform and outlines the resulting policy and operational implications, though the Board asked for other options to be considered<sup>3</sup>. These may become more evident through 2010, and following further engagement with countries.

**Track 1** focuses on harmonising existing programmes and aligning this with country mechanisms. It takes account of the GAVI HSS evaluation and tracking study findings, and will incorporate lessons learned from other evaluations. Analysis of GAVI policies suggests that they are compatible with Track 1 plans. The same appears to be true for the Global Fund's policies and World Bank grant/loan agreements.

**Track 2** relates to the financing of new programmes. Within the second track, there are 2 options. The first (option 1) would base the decision on a joint GAVI/Global Fund proposal and review, using existing WB documentation where possible. Option 2 would base the assessment and funding on a National Health Plan.

The Platform is not exclusive to GAVI/GFATM/WB and WHO. It is open to all stakeholders, many of whom have significant funding, and technical support,

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<sup>3</sup> Decision point 13.2, 'Agreed that GAVI should start work with 4 to 5 developing countries to implement the joint platform during 2010, taking into account the two alternatives proposed by the PPC but also considering other variations according to what best suits implementing countries

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at the country level such as the USG (through the evolving GHI<sup>4</sup> with USAID, OGAC<sup>5</sup>, HHS<sup>6</sup> etc), JICA, UNFPA, UNICEF, CSOs and many others. Funds may be channeled in different ways. This seeks primarily to streamline funding. This platform has the potential to demonstrate how results can be accelerated for MDGs 4, 5 and 6 through linking together, through various channels, broad and 'joined up' support to health systems and national health plans.

The three funding agencies and WHO agree that their contributions to supporting specific types of HSS interventions should be informed by the comparative strengths of each partner. For example, the scope of GAVI and Global Fund investments may remain on 'downstream' activities, while World Bank funding could be directed towards more 'upstream' support. WHO would where appropriate provide normative guidance and technical advice, and would also be an important source of in-country technical support, along with other partners such as bilaterals, CSOs, UNICEF, UNFPA, UNAIDS etc. New models of country driven technical support will be considered, including more use of peer to peer networks that reflect key GAVI and GFATM principles of being country driven and responsive. This was shown in both recent GFATM and GAVI reviews of technical support as well as a GFATM hosted consultation on technical support models.

The paper refers to the outcomes of consultations in various countries, takes account of the outcomes of consultations elsewhere, and describes plans to involve the first countries in the Platform process in 2010.

The work described here takes forward the recommendations of the 2009 GAVI HSS evaluation. The main message of the evaluation is that GAVI should continue to support health systems, but that some of the processes need to change. Specific recommendations include the need to have a proposal assessment process that includes greater country-specific knowledge; that monitoring be better integrated with existing country monitoring processes, including Annual Sector Reviews; and the need for better technical support and capacity building - a serious weakness of current models. The Platform aims to respond to all three of these concerns, and others. The evaluation concluded that, with the recommendations implemented, "many countries will offer opportunities for further investment in HSS activities that are likely to increase the coverage of immunisation and other child and maternal services."

### Request

The Programme and Policy Committee requests that the Board:

- Affirm the critical importance of strong health systems to achieve GAVI's mandate and endorses HSS support which focuses on service

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<sup>4</sup> The Global Health Initiative

<sup>5</sup> Office of the Global AIDS Coordinator (PEPFAR)

<sup>6</sup> Health and Human Services

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delivery bottlenecks, and seeks to achieve outcomes for MDGs 4 (particularly immunisation related outcomes), 5 and 6.

- Request the Secretariat to continue working with GFATM, WB, WHO and others partners (bilaterals, other UN agencies, CSOs, private sector etc) on Track 1 - harmonisation of existing investments to ensure better health outcomes (including immunisation-related), and better value for money.
- Request the Secretariat to continue, based on consultations at country level, to work on the implementation of Track 2 Option 1 through the development of a joint proposal form with GFATM. The joint proposal form would be approved by the PPC, for use as soon as possible. Any funding proposals using this new joint proposal form would be subject to IRC review and Board approval processes.
- Request continued work on Track 2 Option 2 - funding based on national plans, such that 4-5 countries could be approved by the Board, and start implementation in 2010. There will be a particular focus on lesson learning, partner engagement, results and mechanisms for building health systems capacity at country level as part of the implementation (taking account of evaluation findings).
- Request the Secretariat increase dialogue with partners, and develop a communications strategy (with GFATM, WB and others).
- Request GAVI to work with GFATM and other partners in the lead-up to the 2012 evaluation of HSS, to ensure there is an independent evaluation of the Health Systems Funding Platform.

The Board should note that the resource implications will be discussed at the PPC meeting on 18 May for referral to the Board in June.

**FOR DECISION****Health Systems  
Operationalising the Health Systems Platform****OUTLINE**

This paper describes work undertaken since November 2009 to describe the operational, financial and policy implications of implementing a Health Systems Funding Platform. The paper speaks to the decisions made by the Board in November 2009. It also outlines a suggested decision point from the PPC, for the Board. The paper reflects guidance from the PPC in its various meetings in 2009, the meeting on 18 February, and at its most recent virtual meeting on 29 March 2010.

As requested, this paper mirrors the structure and content of the paper on the same subject being prepared for the GFATM Board, which will meet on 28 April. However, all parts have been necessarily adapted to ensure that the concerns of the PPC and GAVI Alliance Board are addressed.

**PART 1: INTRODUCTION**

1.1 In November 2009, the GAVI Alliance Board made the decisions listed below:

- To take forward work with the World Bank, Global Fund and WHO to **develop a Platform for health systems strengthening (HSS)**, in order to support the delivery of vaccines, in consultation with partner countries, civil society, development and funding agencies.
- Agreed that GAVI should **start work with 4-5 developing countries to implement the Platform during 2010**, taking into account the two alternatives proposed by the PPC but also considering other variations according to what best suits implementing countries.
- GAVI should **integrate the recommendations of the GAVI HSS mid-term evaluation and tracking study** into work on the Platform.
- The PPC should report by April 2010 on:
  - How GAVI, the World Bank, GFATM and WHO propose to **operationalise** the Platform
  - **How the joint Platform will be implemented in 4-5 countries in 2010**, including provision of adequate technical assistance
  - How GAVI and other Platform partners will **monitor and learn lessons from implementation** in these countries
  - How the Platform will better enable the **GAVI Alliance** to achieve its **objectives, including in relation to immunisation**
  - **Transition arrangements from existing GAVI HSS support** to the Platform.

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- To **consider the new country HSS proposals** recommended by the October 2009 IRC after reviewing agreed prioritisation principles, available financial resources, potential supply constraints and ongoing work on the joint Platform.
- On the basis of the above, GAVI will decide how best to request new proposals for support to HSS.

1.2 This is the first time that the GAVI and GFATM papers have used the same structure – over time, this process should become more streamlined. In this paper, the five requests made by the Board are all dealt with, but not in the same order as in the Board’s decision point. This was inevitable, if a joint structure was to be used. For convenience, the board decision is summarised in the table below, with the corresponding paragraph numbers given.

Requests from Board (numbers refer to the November 2009 Board decision points/minutes)	Key points of response	Section/Paragraph numbers in this paper
13.1 Decided to take forward work with the World Bank, Global Fund and WHO to develop a joint platform for health systems strengthening, in order to support the delivery of vaccines, in consultation with partner countries, civil society, development and funding agencies.	This paper describes the results of this work. Annex 2 lists the main consultations which have occurred; Annex 3 is the Joint Workplan for the World Bank, Global Fund, WHO and GAVI.	Annex 2 (consultations) Annex 3 (joint workplan with GFATM, WB and WHO)
13.2 Agreed that as part of this, GAVI should start work with 4-5 countries to implement the platform during 2010, taking into account the two alternatives proposed by the PPC but also considering other variations according to what best suits implementing countries.	See detail under 13.4 below	Country implementation: summarised in Box 1.
13.3 Requested the PPC to work with the Secretariat to determine how GAVI should act on recommendations of the GAVI HSS mid-term evaluation and tracking study and integrate these into work on the platform. The PPC should liaise directly with the GFATM Policy and Strategy Committee and appropriate organs of the other platform partners.	The overwhelming messages of the Tracking Study and Evaluation were that GAVI needed to improve its responsiveness to individual country situations; to strengthen monitoring; and to adhere more to the principles of effective aid (harmonisation and alignment). The two Tracks described here put these ideas into practice for both existing and future HSS support.	Paragraphs 2.2 – 2.5. See Annex 5.
13.4 Requested the PPC to report, by April 2010 at the latest on:		
<i>How GAVI, the World Bank, GFATM and WHO propose to operationalise the Platform</i>	<ul style="list-style-type: none"> <li>• In some countries: focus on harmonising/aligning existing HSS grants and credits (Track 1)</li> </ul>	Discussed in detail in Part 3.

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	<ul style="list-style-type: none"> <li>In others: accept a joint HSS application to GAVI and GF (Track 2/option 1)</li> <li>In countries with a national health plan: assess plan and fund HSS aspects (Track 2/option 2)</li> </ul> <p>Eligibility for these different types of support have been specified</p>	Detailed work programme and timeline for the Platform agencies in Annex 3.
<i>How the Platform will be implemented in 4-5 countries in 2010, including provision of adequate technical assistance</i>	<p>Track 1: 3-5 countries in 2010. Work in progress, through joint missions.</p> <p>Track 2: most progress in Nepal and Ethiopia (also Vietnam and Cambodia). Nepal undergone JANS. Ethiopia JANS due in 2<sup>nd</sup> quarter of 2010. Both <i>potential</i> funding requests at June Board.</p>	<p>Country implementation: summarised in Box 1.</p> <p>Technical assistance: paragraphs 4.19 – 4.23.</p>
<i>How GAVI and other Platform partners will <b>monitor and learn lessons</b> from implementation in these countries</i>	<ul style="list-style-type: none"> <li>Country consultations in effect lesson learning exercises.</li> <li>Track 1 work explicitly intended as lesson-learning.</li> <li>Country Responsible Officers to attend as many health sector reviews as possible in 2010 – to feed into changes in 2011.</li> <li>Platform drawing on Global Fund's experience of National Strategy Applications.</li> </ul>	Summarised in Box 2.
<i>How the Platform will better enable the GAVI Alliance to achieve its <b>objectives</b>, including in relation to immunisation</i>	<ul style="list-style-type: none"> <li>In Track 2/Option 2 countries, links between immunisation and health systems should be fully institutionalised, as both are important components of the National Health Plan.</li> <li>Improved monitoring allows more of a focus on whether better health systems are producing better health outcomes, including immunisation.</li> <li>Key area in linking HSS investments and immunisation outcomes is improved communication and co-ordination between health systems and immunisation communities. Platform is opportunity to make clear that funds can be used for systems components related to immunisation (e.g. cold chain, surveillance).</li> </ul>	Paragraph 4.24
<i><b>Transition</b> arrangements from existing GAVI HSS support to the Platform.</i>	<p>Three country groupings:</p> <p><i>Countries already approved for GAVI HSS, likely to end before end 2011.</i> If eligible, focus on readiness to receive Platform funding post 2011.</p> <p><i>Countries already approved for GAVI HSS beyond 2011.</i> Worth considering better alignment and harmonisation</p>	<p>Paragraph 4.26</p> <p>Details in Annex 6.</p>

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	<p>of existing HSS support with country processes and cycles (e.g. taking part in annual health sector reviews, negotiating shared indicators and harmonised fiduciary oversight).. De facto Track 1 countries.</p> <p><i>Countries which have never or unsuccessfully applied for GAVI HSS. These countries would need to be LICs at the start of their planning cycles to be eligible for future GAVI HSS support.</i></p>	
<p><b>13.5</b> Decided that it will consider the new country HSS proposals recommended by the October 2009 IRC after reviewing agreed prioritisation principles, available financial resources, potential supply constraints and ongoing work on the joint platform.</p>	<p>This is being discussed in the prioritisation exercise</p>	
<p><b>13.6</b> Agreed that on the basis of this, GAVI will decide how best to request new proposals for support to HSS.</p>	<p>To be considered after April Board discussion</p>	

1.3 The goal of the proposed Health Systems Funding Platform (the Platform) is to help develop stronger health systems to improve and scale-up coverage and delivery of life saving health interventions. It is focused on MDGs 4, 5 and 6 – on achieving better health outcomes in relation to vaccine-preventable diseases, maternal health, AIDS, tuberculosis and malaria. The Platform aims to achieve these health outcomes and deliver value for money by providing funding for strong national health plans in a coordinated manner. National health plans start with a consideration of the country's health situation and the economics of available interventions, so the overwhelming epidemiological and economic data on the advantages of immunisation will become part of the process of developing national health plans – a process which is at the heart of a government's strategic work in the health sector. National planning processes, and the subsequent implementation of the plans, need to be fully inclusive of the whole range of stakeholders and partners at country level, taking account of partners' roles as financiers, implementers, advocates and their role in mutual accountability.

1.4 An example, which is only indicative, can "bring to life" the links between health systems support and improved health. Current GAVI HSS support in Nepal includes funding for facilities and outreach at the sub-district level. It addresses issues such as the morale of staff working in remote areas; reaching areas which are relatively neglected in terms of immunisation and other maternal/child services; and the collection and use of data from the sub-district level. Nepal is likely to be an early Platform country. The Platform work will be monitored with reference to an agreed Results Framework for Nepal's health sector. Monitoring has been problematic in the past in Nepal. The more

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that development partners concentrate on the same indicators, the more pressure there will be to improve monitoring. Examples of indicators from Nepal's national framework, which are aggregated from district level data, include:

### *Outcome/impact indicators*

- Reduce under-five mortality rate from 51/1,000 live births in 2008 to 38 by 2015, disaggregated by gender, caste/ethnicity, wealth, and region
- Reduce disparity of maternal mortality ratio between castes/ethnicities and wealth by 40%

### *Intermediate indicators*

- % of children under 12 months of age immunized against DPT 3 and measles, at least 85% annually, disaggregated by gender, caste/ethnicity, wealth, and region
- % of institutional deliveries from 18% in 2006 to 40% in 2015
- Utilization of essential health care services by targeted groups by 2015
- At least 5,000 additional Female Community Health Volunteers recruited and deployed in remote districts by 2015.

1.5 The Platform aims to provide more efficient, coordinated support. This should reduce transaction costs and the number of fragmented, duplicative projects which currently dominate health sector support to countries. The transaction costs which the Platform aims to address are enormous. In a recent joint GAVI, World Bank, Global Fund and WHO mission to Ethiopia, the Federal Ministry of Health reported that it has had five audits in six months, runs more than 20 ledgers and has hundreds of reports to produce.<sup>7</sup> The real cost is not just the staff cost; what they are not able to do in service delivery terms - and the cost of audits, but the opportunity cost and losses that might occur due to lack of focus on internal controls and other critical tasks. A recent WHO and World Bank study found that aid fragmentation continues to contribute to high transaction costs and that aid needs to be better targeted to support national plans.<sup>8</sup>

1.6 Following the November 2009 Board, the Secretariat has worked with the Global Fund, the World Bank, WHO and other partners to identify principles guiding the development of the Platform, its scope, and ways to better coordinate, mobilise, streamline and channel the flow of existing and new international resources to support health systems. The work to develop the Platform has involved wide ranging consultations at various levels, including countries (visits to Nepal, Ethiopia, Cambodia and Vietnam and regional consultations in the WHO Africa, Western Pacific, and European Regions), with multilateral and bilateral donors (including USG, JICA, , UNAIDS, UNICEF and UNFPA), civil society and private sector partners. This highlights the need for greater inclusiveness at the country level, and globally,

<sup>7</sup> Ethiopia Platform Scoping Mission: 4-8 February 2010.

<sup>8</sup> WHO, OECD-DAC, WB. 2008. Effective aid, better health: report prepared for the Accra High Level Forum on aid effectiveness 2-4 September 2008.

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as well as the need for a clear proactive communications strategy, particularly for countries. Key findings from the country consultations are at Annex 1. A list of key consultations is at Annex 2.

1.7 The consultations also strongly and consistently support the development of a mechanism that upholds, and is guided by the Paris and Accra Principles,<sup>9</sup> and one which uses (when needed) tools and instruments developed with partners. Examples of these tools are the Joint Assessment of National Strategies (JANS) developed through the International Health Partnership Plus (IHP+) and the IHP+ Country Health Systems Surveillance (CHeSS) framework for monitoring and evaluating health systems.

1.8 The guiding principles of GAVI HSS<sup>10</sup> are generally compatible with the objectives and aims of the proposed Platform – in fact the Platform will further promote the principles. This is because the Platform will provide more country-centered, coordinated support.

1.9 For the Global Fund, the consultations have resulted in the identification of six elements of the Global Fund model which it wishes to be preserved in the Funding Platform.<sup>11</sup> These elements overlap considerably with GAVI's principles.

1.10 The GAVI Secretariat has worked with other agencies on developing and implementing a joint work programme with consultations at country level to ascertain how the two funding options and others may be operationalised in different country contexts. The work programme focuses on:

- i) appraisal/assessment processes and procedures to make new funding decisions
- ii) financial management and procurement processes
- iii) a common performance measurement framework
- iv) mechanisms for harmonised provision of technical support.

Inter-agency working groups have been designated to work on the four areas and focal points have been named. Annex 3 is the joint work programme and timeline. Detailed documentation is available publicly at <http://go.worldbank.org/0D4C6GPQU0> .

1.11 The work has focused on two country “tracks” – these are described in detail in Part 3 of this paper. These are not the only possibilities, but other options might arise as a result of early experience. Track 1 relates to existing health system strengthening (HSS) grants which have been approved by

<sup>9</sup> OECD-DAC. 2008. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

<sup>10</sup> The ten GAVI HSS principles are: country-driven, country-aligned, harmonised, predictable, additional, inclusive/collaborative, catalytic, innovative, results-oriented and sustainability-conscious.

<sup>11</sup> The six Global Fund elements are (i) the inclusive multi-stakeholder model at all levels, (ii) a strong focus on results and performance, (iii) the demand-based model for funding allocation, (iv) the commitment to country ownership, (v) flexibility and innovation, and (vi) robust evaluation to demonstrate impact of HSS investments.

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GAVI and Global Fund Boards in countries where the World Bank also has HSS investments. This work will line up existing investments, and will better align with country mechanisms, using flexibilities that already exist under current policies.

1.12 Track 2 relates to the financing of new HSS programmes. There are 2 options – both are being explored to see how they could be operationalised in various country settings. Option 1 envisages countries submitting a single health systems strengthening proposal to the Global Fund and GAVI. Option 2 involves funding of national health plans that have been jointly assessed through a JANS (or JANS-like) process. Both options envisage harmonisation of country-level performance frameworks (including indicators used to measure the benefits and impact and outcomes from HSS investments), as well as harmonised reporting requirements, fiduciary oversight, procurement and technical assistance. For GAVI (and hence for the Platform as a whole), a prerequisite for supporting a National Health Plan would be a complementary cMYP, (Comprehensive Multi-Year Plan for Immunisation).

1.13 It is important to work on both the Track 2 options. Option 1 is important for the many countries that do not yet have robust national health plans that can be submitted for funding (such as, fragile states). Aligning with country priorities and processes is especially important in these countries due to weak absorptive capacity.<sup>12</sup> Option 2 provides a solid basis for donor harmonisation and alignment with country systems, and incentivises countries to create robust, costed, scalable national health plans, which are also explicit about how CSOs will be funded, either directly, or through other mechanisms. It is important that Option 2 is pursued, if there is a 'good enough' national health plan.

1.14 Having described the two tracks, this paper identifies key issues that need to be addressed before the Platform can be fully implemented. The paper is divided into five parts. Part 2 provides an overview of experience with HSS; Part 3 outlines the key elements of a Platform; Part 4 outlines policy, financial and operational implications and systematically responds to points in the Alliance Board's decisions. The paper then briefly discusses risks and the timeline for next steps in relation to the PPC and Board. Part 5 details the suggested decision point.

## PART 2: EXPERIENCE OF HEALTH SYSTEMS STRENGTHENING

2.1 One of GAVI's current four strategic goals is to contribute to strengthening the capacity of countries' health systems to deliver immunisation and other health services in a sustainable manner. Since 2005, GAVI has been investing in health systems to address system bottlenecks to high levels of immunisation coverage. As of May 2009, US\$524 million worth of grants had been approved to 44 countries, from a notional allocation of

<sup>12</sup> OECD-DAC. 2008. Service Delivery in Fragile Situations: Key concepts, findings and lessons. OECD-DAC Discussion Paper. Paris: OECD-DAC.

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US\$800 million. A summary of key Board and Executive Committee decisions on HSS is attached at Annex 4.

2.2 The 2009 GAVI HSS evaluation<sup>13</sup> recommended that “GAVI HSS should continue its efforts to strengthen delivery systems for immunisation and related child and maternal care. At the same time, however, *“it should also now engage energetically with others with common objectives of building strong health systems across the board able to deliver an affordable range of health interventions whilst maximising synergies and efficiencies. ....”* The development of the Platform addresses this recommendation. The reason for recommending a joint approach was that the evaluation had identified problems with the stand-alone HSS window. One of the main problems was an insufficient understanding of country situations to judge whether the support was *really* tackling a bottleneck to better services. Secondly, there was a disconnect from existing activities such as Annual Health Sector Reviews which could provide intelligence about progress in terms of health systems activities and their relationship to key health outcomes, including their relation to immunisation. In the area on monitoring and evaluation, budgeting and financial flows, GAVI support was assessed as being sub-optimally aligned to national systems.

2.3 The evaluation found clear links between HSS spending, immunisation and wider MNCH. It gave examples of how existing HSS spending is linked with output and outcome indicators related to child health (in addition to the required immunisation indicators). Moreover many of the interventions also have an impact on maternal health or MDG 6:

- Some countries (e.g. Rwanda, Ethiopia and Viet Nam) linked health systems strengthening activities with the number of deliveries attended by a skilled attendant.
- Burundi measured mosquito net coverage
- Zambia, Rwanda and Ethiopia used the indicator of the percentage of children aged 6-12 months receiving Vitamin A.

The Platform should enable these kinds of linkages between health systems support and health outputs/outcomes to be stronger because the support would involve more than one agency and would be embedded in comprehensive plans from the start. Many of the investments would have an impact beyond the health MDGs, as the service delivery platform is the same for many interventions.

2.4 The evaluation described the nature of most GAVI HSS support:

“Countries have pitched most of the activities ‘downstream’ in immunisation and MCH services delivery and in immediate support to delivery of those services, and sometimes in selected districts.....”

“Predominantly, country programmes cover training, strengthening management and supervision, and procuring supplies and equipment

<sup>13</sup> GAVI Health Systems Strengthening Support Evaluation 2009. Volume 1: Key findings and recommendations.

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and improving their management, and many include improvements to information collection and use....”

This downstream spending focus is not surprising: service delivery level interventions are more manageable, reflect the role of EPI departments in programme design, and are the emphasis of GAVI HSS guidelines and intentions. In contrast, more systemic change must be more politically driven and requires substantial investment, such as that provided by the World Bank, Regional Development Banks etc. Downstream interventions are likely to improve the quality and quantity of services delivered. They are broadly consistent with the ‘Reach Every District’ Strategy that has been promoted and supported in many countries since 2002.

2.5 Annex 5 summarizes the issues raised by the HSS mid-term evaluation, the 2009 tracking study and the GAVI Phase 1 evaluation. There are seven main topic areas:

- **Technical support.** Need for better coordinated, country led, timely and higher quality technical support.
- **Improving processes.** Weaknesses in the processes related to decisions about applications and funding
- **Monitoring.** Need to strengthen monitoring of GAVI HSS
- **Alignment.** Need to align more with country planning and budgeting cycles
- **Communication and partnerships.** Need to improve communications to and within countries, and at global level. Need to take HSS coordination and partnerships forward,
- **Risk management.** Risk management and good practice in financial management and procurement.
- **Civil Society.** Stronger involvement of Civil Society.

2.6 HSS investments by the Global Fund are similar to those by GAVI in terms of their focus on downstream spending.<sup>14</sup>

2.7 For the World Bank, investments in HSS are more wide-ranging, focusing on health systems performance, including programmes and policies that aim to bring about improvements in the management, financing and overall functioning of health systems, as well as considerable support for infrastructure. There are several sources of funding, primarily support through IDA, which uses the Country Assistance Strategy process, and the Results Based Financing Trust Fund (announced in September 2009). Examples of WB support include improving the use of results-based financing, increasing provision of health insurance for the poor (Rwanda), and developing new

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<sup>14</sup> An analysis of proposals approved by the TRP in Rounds 8 and 9 shows that funding demand was primarily for health services (~75%), followed by M&E/health information systems (~16%), stewardship & governance (~10%), and health financing (~1%). Shakarishvili *et al.* 2010. *Towards a common classification of health systems strengthening: an analytical framework for tracking donors HSS investments.* Draft February 2010.

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service delivery models, such as the contracting-out of primary health care services (Afghanistan).

2.8 The three agencies and WHO agree that their contributions to supporting specific types of HSS interventions should be informed by the comparative strengths of each partner. For example, the scope of GAVI and Global Fund investments may remain on ‘downstream’ activities to address service delivery bottlenecks, M&E, supply chain management and other relevant areas, while World Bank funding could be directed towards more ‘upstream’ support such as policy and governance, stewardship, healthcare financing and infrastructure development. Where appropriate, WHO would provide normative guidance and technical advice, and would also be an important source of in-country technical support, along with other partners such as bilaterals, CSOs, UNICEF, UNFPA and UNAIDS. New models of country driven technical support and capacity building will be considered, including more use of peer to peer networks, reflecting key GAVI and GFATM principles of being both country driven and responsive.

### PART 3: KEY ELEMENTS OF THE HEALTH SYSTEMS FUNDING PLATFORM

3.1 This section starts by describing in more detail the two proposed tracks of the Platform. It then discusses the next steps and implications for GAVI and other Platform partners. The November Board asked the PPC to report on how the joint Platform will be implemented in 4-5 countries in 2010. For convenience, key points are summarised in Box 1 at the end of this section. The Board also asked for a description of how the Platform will be operationalised – in effect this is the subject matter of the whole of this Part 3.

3.2 What the Platform is. The Platform would be based on three key elements at country level which GAVI, the Global Fund and the World Bank (and others) would support:

- **One national health plan or health systems strengthening proposal** (developed in an inclusive process with full multi-stakeholder engagement).
- Harmonised fiduciary oversight, with **one financial management and procurement arrangement** (supporting a pharmaceutical management system) with shared audit.
- **One performance framework** which consists of one shared reporting format aligned with national cycles (for example, an annual report linked to joint annual reviews, and longer-term periodic reviews), and one M&E system with shared indicators to ascertain the benefits and impact of HSS on MDGs 4, 5 and 6.

3.3 These three elements represent the language used in global and national contexts when discussing how the Paris principles and IHP+ objectives can be operationalised. However another major issue is also emerging – the need for **one technical support framework**.

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3.4 The Platform aims to provide a framework for development partners to better align future HSS support with countries' priorities and cycles (as a basis for harmonisation). It would provide a channel to finance a country's national health plan in a longer-term, more predictable and results-focused manner. It should reflect all available funding opportunities at country level. Its guiding principles include:

- Focus on country results and value for money
- Inclusiveness of all key stakeholders
- Commitment to Paris and Accra principles
- Flexible/differentiated approach for different countries to ensure alignment and locally relevant solutions
- Common frameworks for HSS and a harmonized approach to program development, approval, and implementation
- Improved information sharing between partners, countries and donors.

The Platform is based on what is known about aid effectiveness – support that respects country priorities and is well coordinated with other activities is more likely to result in positive health outcomes, including in terms of vaccine-preventable diseases.

3.5 What it will not be. The Platform will not be a global pooled HSS fund or a new entity. The key elements are at country level - the role and commitment of the three funding agencies and WHO is to support the country Platform through improved alignment to country plans and planning cycles. There are many actors at country level, and, it bears repeating, that this platform is for all interested external funders, technical support providers, and in many cases will merely build on what is already being done.

3.6 The Platform would involve two tracks, with consultations at country level critically informing their development. Track 1 focuses on harmonising existing programming and aligning this with country mechanisms. Track 2 focuses on two options for supporting national health plans. These two tracks are outlined in more detail below, including what can be done using existing flexibilities, and the criteria for selecting countries.

### **Track 1: Developing a Funding Platform Using Existing Investments**

3.7 Work on Track 1 is already starting. This does not require any major changes as it responds to evaluation and tracking study findings. The four agencies will start work in 3-5 countries where GAVI, the Global Fund and World Bank already support HSS activities. It could rapidly be extended to more countries, if the necessary capacity is available. For GAVI in particular, there is a need to expand the capacity of the secretariat in terms of HSS.

3.8 Track 1 is about simplifying planning, financing and monitoring procedures so that countries can concentrate on removing bottlenecks and

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achieving better health results. It is important to establish the baseline, benchmarks, and indicators that would demonstrate results. Track 1 aims to:

- Simplify processes, increase efficiency and reduce transaction costs.
- Provide practical experience regarding how to implement harmonisation and alignment in different country circumstances.
- Provide a foundation for channeling future joint HSS funding through the Platform.

3.9 Alignment and harmonisation of programming in 6 to 8 countries in 2010 should demonstrate progress in the following areas:

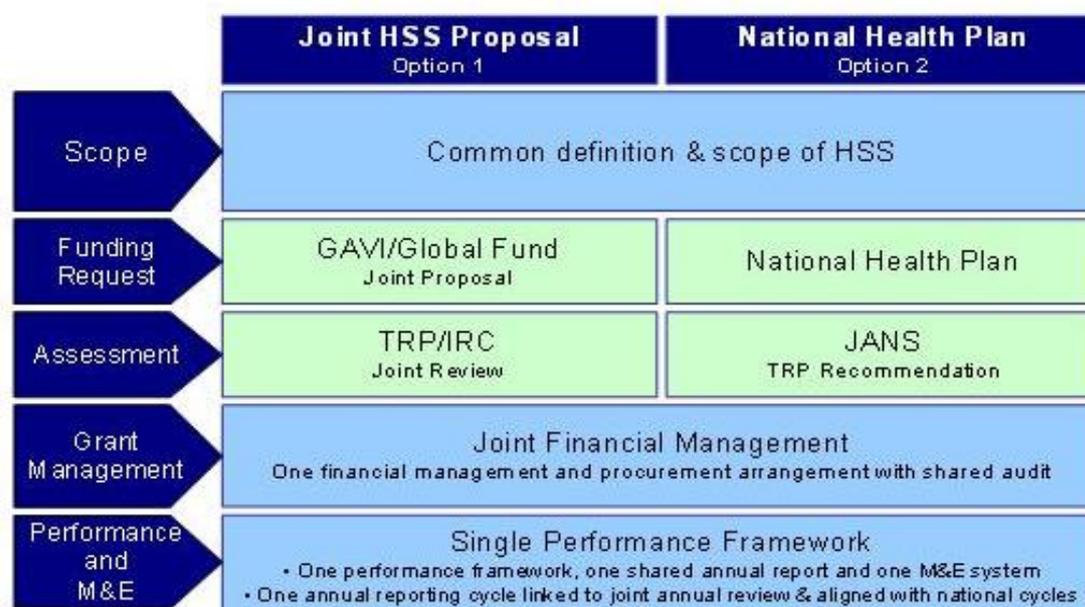
- Re-programming of current HSS support to achieve greater complementarity among various programmes, and better alignment with national health strategies.
- Development of a common HSS performance framework, with a common reporting system, and a monitoring and evaluation system aligned with a country's health management information system (HMIS). This would involve a common set of indicators, including those that reflect MDGs 4, 5 and 6.
- Development of common approaches to programme oversight including procurement, auditing, financial management and reporting – all aligned with country systems.
- Harmonisation of disbursements of existing HSS support, aligned whenever possible with countries' planning and budget cycles.
- Coordination of HSS technical support and capacity building mechanisms.

3.10 Currently, country selection criteria for track 1 are: current, or soon to be approved, HSS support from the three funding agencies which would last for at least two years and which are substantive; the country is interested in better harmonisation and alignment; and existing joint annual health sector reviews as a basis for alignment. Negotiations with countries meeting these criteria are ongoing.

3.11 Analysis of GAVI programmatic policies suggests that they are compatible with Track 1 plans – in other words it appears that programmatic harmonisation can be implemented without undertaking noteworthy changes in existing organisational policies and agreements. The same appears to be true for the Global Fund's policies and World Bank grant/loan agreements.

### **Track 2: Developing a New Funding Platform**

3.12 For Track 2 countries, the aim is to have a more comprehensive health systems plan, which is part of the wider national targets for health improvements. Track 2 would focus on the development of Options 1 and 2, as outlined in Figure 1. As stated in paragraph 3.4, a single framework for technical support is also an integral part of both Options.

**FOR DECISION****Figure 1 - Track 2: Comparison of Key Elements of Option 1 and 2****Option 1: Joint GAVI and Global Fund HSS Proposal**

3.13 In Option 1, the Global Fund and GAVI would prepare one proposal form, which would be based on existing forms and would link the HSS proposal to immunisation plus one of HIV, AIDS or TB. The two agencies would agree on one M&E framework and indicators. Countries would then apply:

- (i) to GAVI, as per current arrangements but using a common application form
- (ii) OR through the CCM to the Global Fund (as per current arrangements but with common application form)
- (iii) OR as a joint application to both GAVI and the Global Fund, indicating the funding requested from each agency.

Existing Global Fund HSS funding channels would be kept open.

3.14 Joint proposals would be jointly reviewed and recommended for funding by a combined GAVI IRC/Global Fund Technical Review Panel (TRP), with HSS experts, and possibly including WB and WHO expertise. Once agreed, processes would follow each agency's existing cycles and practices. The operational cost of the IRC could increase in the short term, due to the greater volume of review materials, and the time needed for review and recruitment of HSS experts. Consideration needs to be given to changes to the proposal form, which the PPC could advise upon. The Board will need to review the ToR for the HSS IRC/TRP.

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3.15 Clear guidance would be given to countries to ensure the use of one financial management and procurement framework and one performance framework. The performance framework should derive from national plans and be linked to national cycles. Reporting would be underpinned by a country led, joint annual review process. GAVI and the Global Fund (through its new architecture) are already working to align their reviews and procedures to the country cycles. Work on Track 1 would also inform this process.

### ***Option 2: Funding for HSS based on national health plans***

3.16 **Initial countries.** Option 2, which is based on funding national health plans, could be tried in up to six countries beginning in 2010. Countries would be identified using transparent criteria. Countries would be low income (either IHP+ or non IHP+<sup>15</sup>) with a robust national health plan ready for joint assessment. Countries would request funding partners to assess national health plans which include HSS actions that are clearly costed and budgeted and that demonstrate benefits for immunisation, maternal health, and AIDS/TB/malaria (MDGs 4, 5 and 6). There will be an issue, to be considered in the context of the prioritisation exercise, about what will happen to future HSS funding in the GAVI countries that are not in the LIC category<sup>16</sup>. It would be essential that the Platform includes a results focus and that the proposed performance framework attached to the national health plan clearly indicates the results targets for immunisation and MDGs 4, 5 and 6, as well as the HSS targets.

3.17 **Assessment.** Option 2 would involve an in-country assessment using JANS (Joint Assessment of National Strategies) that included selected IRC and TRP members. The Joint Assessment would be a formative process with intensive input from technical partners to help develop the national health plan and appropriate HSS actions, ensure harmonisation and alignment of performance frameworks etc. The Health Sector Coordinating Committee (HSCC) and CCM (which often have overlapping membership) would participate in developing the national health plan, and take part in the JANS. Hopefully, this would stimulate discussion on the many coordination mechanisms for HSS at country level, and lead to further streamlining - as happened in Rwanda and Nicaragua.

3.18 **Funding request.** Following the JANS assessment and the finalisation of the national health plan, the country would submit a formal 'funding request' with the national health plan as the key document. This would be submitted to GAVI, the Global Fund, the World Bank and other partners. It would indicate the financing gap, areas where funding is required, and the amount requested

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<sup>15</sup> IHP+ partner countries, are Benin, Burkina Faso, Burundi, Cambodia, Democratic Republic of Congo, Djibouti, Ethiopia, Kenya, Madagascar, Mali, Mozambique, Nepal, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Uganda, Vietnam and Zambia.

<sup>16</sup> There are currently 43 LICs in the WB list. This leaves 15 countries (with the new eligibility policy) of the overall 58 GAVI countries who will need to know whether they can apply for HSS funding in future

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from each partner. GAVI will need to adjust the timing of its responses to funding requests, in order to align with country planning and budgeting cycles. The Board will need to consider developing a more flexible timing of funding decisions.

3.19 Requests for Global Fund funding would be submitted by the CCM or by another mechanism which meets the Global Fund's six minimum requirements for CCMs<sup>17</sup>.

3.20 Each proposal would be assessed by the agency that receives it. For the Global Fund and GAVI, this would include a joint IRC/TRP review, as suggested for Option 1. Ideally, if the JANS process is robust, this will be light touch, and result in a joint IRC/TRP recommendation to the Board(s). Other funders support would be reflected, and others who are not yet funding, but are interested, might choose this channel to fund at country level. Experience with a few joint assessments will be required before it is known what this "light touch" would need to include.

### *Next steps and implications*

3.20 **Countries.** Potential Track 1 and 2 countries have been identified in collaboration with other partners and the core team in the International Health Partnership (IHP+). Crucial timing decisions are not within the control of people working on the Platform – it depends on when existing health systems support ends and when national health plans are developed. There could be overlap between Tracks 1 and 2. This would happen for a country with existing HSS support and with a new planning cycle beginning within the next 2 years.

Track 1 countries could include ***Ethiopia, Nepal, Liberia, Senegal, Sierra Leone and Cambodia and others.***

Track 2 countries could include ***Nepal, Ethiopia, Benin, Sierra Leone, Tajikistan, Vietnam, Mali, Cambodia and others***<sup>18</sup>.

The Track 2 countries which are potentially closest to a Platform decision point are Nepal and Ethiopia. Nepal has undergone a joint assessment of its national health plan. This assessment was reviewed by an IRC member and the secretariat. It is expected that Ethiopia will also undertake a joint assessment in April. Both these joint assessments could *potentially* lead to funding requests at the June Board, or earlier<sup>19</sup>, dependent on certain minimum criteria being met. Assessments are also likely to take place in

<sup>17</sup> Minimum Requirements of a CCM (Global Fund) - transparent selection process for membership of non-governmental members; membership of persons affected by HIV/AIDS, TB, and malaria; transparent and documented process to solicit and review proposal submissions; transparent and documented process for nominating the Principal Recipient (PR) and to oversee program implementation; ensured input of a broad range of stakeholders; when PRs and CCM Chair or Vice Chair are the same entity, CCMs must have a conflict of interest plan.

<sup>18</sup> In the case of Cambodia, this would not involve a JANS.

<sup>19</sup> Nepal – this might be presented for an earlier funding decision.

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Vietnam and Cambodia in April 2010. Rwanda and other countries that might be of interest to PEPFAR/GHI are also possible.

**3.21 Monitoring and evaluation.** The next steps are to operationalise the monitoring and evaluation approach previously reviewed by the PPC. Joint missions in Track 2 countries will develop details on how this will be operationalised. WHO is the lead in coordinating this work, which builds on work already undertaken through the IHP+ Monitoring and Evaluation Working Group and the Country Health Systems Surveillance (CHeSS) Platform. As part of this effort, WHO is convened a workshop in Kenya from 12-16 April with representatives from 6 East African countries, including Ethiopia.

**3.21 Eligibility.** In December 2009, countries were informed that new commitments would not be made until mid 2010, after a prioritisation and resource mobilisation exercise planned for March 2010. Countries were also told that there would be no new HSS proposals using the previous HSS design until further notice. Presently, the Platform thus effectively replaces the HSS window for future grants for GAVI. This means that future HSS funding will only be available to Low Income Countries, as recommended by the Innovative Financing High Level Task Force – it will not be available to all GAVI-eligible countries. (This is discussed further in section 4.)

**3.22 Resource envelope and CSO/community support.** GAVI anticipates additional new resources for HSS (through the expanded IFFIm), and will continue with CSO support. The Global Fund has not yet specified how it will decide on the level of overall resources made available for the Platform. It is currently reviewing its resource mobilisation and use. However the Global Fund will continue to support dual-track financing and community systems strengthening, as well as other HSS requests (outside of the countries under the Platform) in parallel to the Platform.

**3.23 Financial management and procurement.** Alignment of financial management and procurement systems at country level is a key element of Option 2. The three agencies, and any others who wish to, would agree to:

- Align their existing mechanisms to channel funds
- Align timing of disbursements to countries cycles
- Use one shared tool for assessment of financial management and procurement systems (or agree on a country by country basis to accept the results of each others' assessments)
- Share audit arrangements (not agency specific audits), and standards for financial management (e.g. through a joint financing arrangement).

The proposed introduction of the Platform at country level will provide the opportunity to specify the changes required within GAVI to achieve this - including possible changes to the Financial Management Assessment process. The Global Fund will look at the implications for the terms of reference of its Local Fund Agents.

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**3.24 Shared performance framework, one annual report.** Options 1 and 2 would require the effectiveness of support to be monitored through one agreed performance framework shared by all three agencies (plus other bilateral and multilateral partners,) one shared annual report (rather than separate reporting requirements), and one M&E system. The most important element of this approach, is the ‘feedback loop’ which allows all to learn lessons from implementation, to adjust and change course as needed, and to put in place steps to improve performance. Where necessary, recommendations could be made for partners to fund operational research, which would allow for ‘learning by doing’. Ensuring adequate lesson learning will not happen without considering how operational research can be integrated into the process.

**3.25 Performance Based Funding.** The GAVI Performance Based Funding Task Team (which includes WB, GFATM, WHO and bilateral representatives) is concentrating on how GAVI’s results focus can be maintained and most appropriately integrated into all of its windows of support. The Task Team has completed its schedule of meetings and is in the process of finalising its report to the Secretariat. The Secretariat will then prepare a workplan based on the report and present it to the PPC. The Secretariat is working with the Chair of the Performance Based Funding Task Team to explore options for in-depth work with Track 2 countries on how performance based approaches can best be integrated into the Platform to support improved outcomes. This includes those related to vaccine-preventable diseases.

**3.26 Technical support.** For both Options 1 and 2, there would be a need to link the Platform at country level, with the coordinated provision of technical support for HSS from development partners. Technical support for HSS should become more demand-driven, targeted, quality-assured and coordinated, as recommended by the HSS evaluation. There should be no global prescriptions developed for technical support, but the Platform will engage with bilaterals, OECD, CSOs and many others who are involved in defining principles for demand driven, high quality technical support. This is an integral element of the joint workplan (See Section 4).

**3.27 Evaluation.** The issue of how to evaluate Platform success evaluated has arisen in various consultations. An independent evaluation is essential. The GAVI Secretariat has been working with the GAVI Board Evaluation Advisory Committee to develop systematic, forward-looking evaluation systems with a strong element of independence and feedback loops to support timely use of evidence for decision making. The GAVI Secretariat has conducted initial consultations with WHO, GFATM and the World Bank on the development of these systems. It is envisaged that these forward-looking systems will serve as the basis for the independent evaluation of the Platform. Rather than a one time evaluation that looks backward, it will be designed as a forward-looking approach designed in advance, with ongoing collection of data in real time and annual reporting of results. It is the recommendation of the GAVI Secretariat that this be added to work plan item 4 and that the GAVI Secretariat take the lead role among the agencies in

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taking this forward. This will be achieved by working closely with the other agencies and establishing clear linkages to the Country Health Systems Surveillance Platform which will be used as the basis for development of M&E systems for the Platform. The GAVI Board Evaluation Advisory Committee would continue to provide guidance to the GAVI Secretariat in developing this further. The evaluation of the Platform would focus on aid effectiveness, reduced transaction costs and the Platform impact on overall funding levels for health systems. The Platform's impact on health system performance would also be evaluated, including whether it has resulted in better national health plans, scaled-up delivery of health services or contributed to improved immunisation coverage and other health outcomes.

**3.28 Link with GFATM's new architecture.** The Global Fund has a new architecture enabling it to participate more fully in the Health Systems Platform. The Platform is compatible with this new architecture – both are based on a programmatic approach to HSS.

**3.29 Other partners.** As work on the Platform is progressing, links will be made with other external donor initiatives, including the new Global Health Initiative (GHI) of the US Government, and PEPFAR, both of which have a focus on health systems. Efforts will be made to harmonise and align with possible PEPFAR and GHI investments in Track 1 and 2 countries.

### Box 1

#### Actions related to implementation of the Platform in 4-5 countries in 2010

- There is a Platform workplan for the four agencies. Four thematic work-streams have been detailed and focal points named. Work is under way, with regular video-conferencing to monitor and liaise.
- Potential Track 1 and 2 countries have been identified in collaboration with other partners and the core team in the International Health Partnership (IHP+). Track 1 countries could include Ethiopia, Nepal, Liberia, Senegal, Sierra Leone and Cambodia. Track 2 countries could include Nepal, Ethiopia, Benin, Sierra Leone, Tajikistan, Vietnam, Mali and Cambodia<sup>20</sup>. Note that crucial timing decisions are not within the control of people working on the Platform – it depends on when existing health systems support ends and when national health plans are developed. There could be overlap between Tracks 1 and 2 – this would happen for a country with existing HSS support and with a new planning cycle beginning within the next 2 years.
- The Track 2 countries which are potentially closest to a Platform decision point are Nepal and Ethiopia. Nepal has undergone a joint assessment of its national health plan. This assessment was reviewed by an IRC member

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and the Secretariat. It is expected that Ethiopia will also undertake a joint assessment in April. Both these joint assessments could *potentially* lead to funding requests at the June Board, or earlier, dependent on certain minimum criteria being met. Assessments are also likely to take place in Vietnam and Cambodia in April 2010. Rwanda is also a possibility.

- Other country visits are planned in conjunction with annual health sector review processes. It is expected that 6-8 Track 1 countries will be visited in 2010.
- Efforts will be made to harmonise and align with relevant PEPFAR and US Global Health Initiative investments in Track 1 and 2 countries.

### PART 4: POLICY, FINANCIAL AND OPERATIONAL IMPLICATIONS

This section discusses issues related to the policy and operational implications of the Platform. The list of issues comes from two main sources, in keeping with the spirit of joint documentation with the Global Fund. One source are areas where particular work has been requested by the GAVI Alliance Board or PPC. The other source is the Global Fund's Policy and Strategy Committee (PSC), which also draws on WB, WHO and other sources. The issues are:

- I. The scope of GAVI support for HSS within the Platform
- II. Potential new resources - volume and funding channels
- III. Country eligibility for HSS funding
- IV. Funding based on National Health Plans
- V. GAVI-wide resource allocation and support for the Platform
- VI. Inclusiveness - civil society and the private sector
- VII. Technical support
- VIII. The Platform and GAVI's objectives, including in relation to immunisation
- IX. Monitoring and learning lessons from implementation in participant countries
- X. Transition arrangements from existing GAVI HSS support to the Platform.

Part 4 ends with a brief discussion of risks and a timeline of events related to the PPC and Board.

#### *I The scope of GAVI support for HSS within the Platform*

4.1 The scope of the proposed Platform is fully compatible with the scope of existing GAVI support for HSS. The objective of GAVI HSS remains fully relevant, "to achieve and sustain increased immunisation coverage through strengthening the capacity of the health system to provide immunisation and other health services (with a focus on child and maternal health)." As with the

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existing HSS window, the aim of the Platform is to remove bottlenecks to the use of high-quality, effective health services.

4.2 The Global Fund, GAVI, World Bank, and WHO, contributions to supporting HSS interventions through the Platform should continue to be informed by their comparative strengths as outlined in Section 2.

### *II Potential new resources - volume and funding channels*

4.3 The Innovative Financing High Level Task Force recommended that the Platform should include “new and existing resources.”<sup>21</sup> The initial additional source of new funding for the Platform is the US \$1 billion expanded International Financing Facility for Immunisation (IFFIm) for health systems. This will translate into about \$650 million up to 2015 – about \$120 million per year. GAVI is the only beneficiary of IFFIm funding for health systems. Such funds can be used for proposals approved under the Platform.

4.4 Funding from the World Bank’s Results Based Financing Trust Fund (US \$450 million), and regular WB resources through IDA, will support HSS activities under the Platform. A number of donors have indicated that progress on implementing the Platform could result in additional resources, especially if benefits to MDGs 4, 5 and 6 are demonstrated. This could leverage additional funding at country level from other health partners around the national health plan, with its HSS elements, and the focus on achieving the health MDGs.

### *III Country eligibility for HSS funding*

4.5 The Innovative Financing High Level Task Force recommended that only low-income countries (LICs) be included in the Platform. The 43 current LICs are the only countries which could be eligible for new GAVI HSS funds as part of the Platform.<sup>22</sup> This reflects the February 2010 PPC guidance that, “eligibility for new HSS funding be only for Low Income Countries as defined by the World Bank (LICs) as intended by the High Level Task force recommendations”

4.6 An Alliance Board decision is awaited about the 9 countries which were recommended for approval of HSS funds by the IRC in October 2009. This is being considered in the prioritisation exercise. The PPC in its 18 Feb meeting recommended that the Board/EC should consider ‘funding in principle’ of these proposals.

4.7 In 2010, the Global Fund accepts funding requests for HSS from 125 countries. Country eligibility for overall Global Fund support for HSS will not change as a result of the Platform.

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<sup>21</sup> High Level Task Force on Innovative Financing for Health Systems, Final Report, 2009. [http://www.internationalhealthpartnership.net/CMS\\_files/documents/un\\_general\\_assembly\\_meeting\\_outcome\\_document\\_EN.pdf](http://www.internationalhealthpartnership.net/CMS_files/documents/un_general_assembly_meeting_outcome_document_EN.pdf)

<sup>22</sup> GAVI as a whole accepts requests from countries with a GNI *per capita* of less than \$1,500 – the exact list will be available later this year.

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### IV *Funding based on National Health Plans*

4.8 Option 2 would require GAVI to make a funding decision based upon a national health plan which (i) has been developed through a fully inclusive process (ii) demonstrates expected results in terms of immunisation coverage (iii) outlines clear HSS elements for funding and (iv) demonstrates contribution to achieving MDGs 4 and 5. A crucial strength of Option 2 is that it enables discussion of *how* a country is tackling and resourcing MDGs 4, 5 and 6.

4.9 As for GFATM, support based on National Health Plans requires a new decision by the GFATM. This will be presented at the 28-30 April Board meeting.

### V *GAVI-wide resource allocation and support for the Platform*

4.10 GAVI has a separate HSS funding window with earmarked funds for HSS. The current system for resource allocation of GAVI HSS funds is based on GNI per capita and numbers of newborn per year (GNI pc <\$365 potentially get \$5 per newborn per year and GNI pc >\$365 get \$2.50 per newborn per year for duration of national health plan). This system is well understood by countries and helps give an overall predictable budget for approved grants.

4.11 However there are some issues around this method of resource allocation in the context of the Platform.

- **Eligibility for new funding through the platform:** Any new funding through the Platform would be for Low Income Countries (as per WB classification) only.
- **Overall amounts available for HSS:** This is currently not known.
- **'Floors' and 'Caps':** The PPC asked for some general principles that could be applied when considering budget envelopes (or floors and caps) for countries.
- **Global Fund and World Bank do not have 'caps'** – a system needs to be devised that is acceptable to all the Platform's agencies.

4.12 Some preliminary work has been carried out on allocating the HSS resources amongst countries. There is further analysis being done on this issue, and the Secretariat will present further work on this issue to the PPC in May. The issue needs to be finalised before any platform funding is approved (see Annex 7 for more details.) The challenge for GAVI is three-fold – how to match demands with available resources; how to allocate resources in ways which best reflect GAVI's mandate; and having a system which is simple to understand, and is acceptable to other Platform partners.

4.13 In terms of matching demands to resources, the current approach (\$5 per newborn in a LIC) would require about \$540 million; increasing the allocations to \$6 would require about \$650 million; \$9 per newborn would require about \$970 million. (The total resource envelope is currently uncertain

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but is likely to vary between \$600 million (the minimum available through IFFIm) and \$940 million.)

4.14 A first stage in changing the resource allocation method would be for the PPC to recommend to the Board what the general principles should be i.e. what should be the trade-off between equity (investment in countries with low coverage levels) and efficiency (many low coverage countries have problems absorbing and using funds efficiently)? Is it relevant that the costs of inputs vary significantly between countries? Should there be a minimum grant available for small countries? And – whilst thinking about these issues – there is an extremely strong case for keeping the resource allocation formula as simple as possible.

4.15 For the Global Fund, the situation is different. There are no earmarked HSS funds, and HSS funds are not distinguished from other core funds. A paper considered by the Global Fund PSC in March proposed that funding under the Platform should be integrated within the existing prioritisation process, rather than managed separately with earmarked funding.

### *VI Inclusiveness - civil society and the private sector*

4.16 Applying for, and oversight of, GAVI HSS grants is currently the responsibility of country Health Sector Co-ordination Committees (HSCCs). The membership of these Committees varies greatly from country to country. The JANS process includes a role for civil society and the private sector. This enhanced role in planning (and potentially in implementation) – particularly for CSOs – is strongly supported by GAVI. CSOs need to be fully involved, not only in the planning processes, but their roles as existing or potential service providers and as advocates, need to be embedded (and funded) in the implementation plan.

4.17 With GFATM the principles are essentially the same, but the mechanisms are different. The Global Fund's principle of inclusiveness – i.e. civil society and private sector involvement in health programming - is realised through the submission of funding requests by CCMs. The Global Fund and GAVI (and the World Bank for Option 2) would need to agree on a way for countries to submit joint applications for Platform funding so that the submission process is inclusive of all in-country stakeholders including civil society, the private sector, and people affected by the diseases. Proposals could be submitted by an HSCC (or any other coordinating body deemed appropriate) that meets the GFATM's requirements for participation as required for the CCMs.<sup>23</sup> Proposals could also be endorsed by both an HSCC and a CCM. However, in implementation, discussion should take place on how to streamline these arrangements.

<sup>23</sup> Minimum Requirements of a CCM (Global Fund) - transparent selection process for membership of non-governmental members; membership of persons affected by HIV/AIDS, TB, and malaria; transparent and documented process to solicit and review proposal submissions; transparent and documented process for nominating the Principal Recipient (PR) and to oversee program implementation; ensured input of a broad range of stakeholders; when PRs and CCM Chair or Vice Chair are the same entity, CCMs must have a conflict of interest plan.

**FOR DECISION***VII Technical support*

4.18 Current technical support mechanisms are often fragmented, unsustainable, not necessarily responsive to country needs, of mixed quality and with no opportunity for countries to provide feedback. Much technical support in the past has been for drafting proposals, rather than for implementation or monitoring. These issues were raised both in the HSS evaluation and the Tracking Study. It is important that technical support is available to ensure that implementation proceeds as planned, that all necessary activities are undertaken, and that support is focused on ensuring that outcomes in relation to child health and immunisation, MDG 5 and MDG 6 are achieved.

4.19 In the last year both the Global Fund and GAVI have undertaken reviews of technical support provision. These were followed up at a meeting in January 2009 hosted by the Global Fund.

4.20 One of the 4 work areas in the joint workplan is “Strengthening support mechanisms and partnerships to improve the performance and monitoring of HSS and the Platform” which includes technical support. Track 1 countries provide an opportunity for some practical progress with the harmonization of technical support for *current* loans/credits and grants. Work in 2010-11 will focus on how to develop a country based ‘one plan’ for technical support, including how it will be resourced, monitored and quality-assured. Lessons from Track 1 can inform the development of Track 2.

4.21 The IHP+ joint assessment process (JANS) could provide an opportunity for countries to explicitly state what sustainable technical support or capacity building may be required. It also provides an opportunity for agencies to play to their comparative advantages when technically supporting countries. The World Bank has already set up technical hubs across Africa and WHO is scaling up its efforts to support countries in drafting and implementing robust national health plans. Technical support provided to the initial Platform countries could be harmonised amongst GAVI, the Global Fund, World Bank, WHO and many other partners, including in the GHI focus countries. There is a real need to open up TS to other providers, to make genuine local capacity building efforts and to develop peer networks (i.e. South to South exchange). Quality is a key factor. Too often countries have commented that technical support is of variable, sometimes poor, quality.

4.22 Some concern has been expressed by countries and development partners that the Platform may primarily benefit LICs which are relatively advanced with their health systems and health plans. Countries with weak national health strategies may need more technical support before they can benefit from the Platform. This is explicitly addressed in the joint workplan (GAVI, GFATM, WB and WHO)<sup>24</sup> and is a focus of other initiatives, including the plans outlined under the Global Health Initiative (of the US government).

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<sup>24</sup> See Annex x

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### *VIII The Platform and GAVI's objectives, including in relation to immunisation*

4.23 The Alliance Board asked the PPC to report on how the Platform will better enable the GAVI Alliance to achieve its objectives, including in relation to immunisation. The links between immunisation and health systems support will be strengthened in three main ways. *First*, in Track 2/Option 2 countries, the links between immunisation and health systems should be fully institutionalised, as both are important components of the National Health Plan. *Second*, the role of improved, more consistent monitoring has already been described (see, for example, paragraph 1.5). Improved monitoring allows more of a focus on whether better health systems are producing better health outcomes, including in terms of vaccine-preventable diseases. *Third*, a key area in linking HSS investments and immunisation outcomes is improved communication and co-ordination between the health systems and immunisation communities at national and at global level. This has been a challenge for GAVI since the opening of the HSS window in 2006. The development of new guidelines will provide an opportunity to make clear to both the immunisation and health systems communities that the Platform could fund systems components of cMYPs (comprehensive immunisation plans), including the cold chain and surveillance.

### *IX Monitoring and learning lessons from implementation in participant countries*

4.24 Mechanisms for learning from past experience and participant countries are described in Box 2.

#### **Box 2**

##### **Monitoring and learning lessons from implementation in participant countries**

The current **country consultations** are in effect lesson learning exercises – as demonstrated in Annex 1. These consultations bring out points which need to be incorporated into the design of the Platform.

Work with the **Track 1 countries** is explicitly intended to be a lesson learning exercise. The Track 1 initiative gives the opportunity to focus on learning from existing grants, SWAps and projects with HSS elements. The new model can inform the three funding organisations on how best to harmonize and align processes such as monitoring and technical support. These consultations will also inform how the Platform could work in different contexts, such as fragile states.

GAVI Country Responsible Officers will attend as many **annual health sector reviews** as possible in 2010. This will feed into the planned changes for 2011 - as from 2011, country level annual health sector reviews in Track 1 countries will be used as the mechanism for annual appraisal of implementation.

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However, in the spirit of ‘joined up’ working, GAVI has the benefit of being able to draw on GAVI Alliance partners’ presence in these processes, and, as this evolves might be able to draw more on partners (including GFATM). This will reduce transaction costs for countries, and for GAVI.

The Platform can draw on the experience of the **Global Fund’s first learning wave of National Strategy Applications (NSAs)** approved in November 2009. A key lesson from the NSAs is that few countries may have readily fundable health strategies with distinct HSS elements. NSA experience also shows that implementing new models is a complex exercise that needs to be adequately resourced.

As well as being useful at global level, this **lesson learning will be appreciated at the country level** - the GAVI HSS Tracking Study noted a strong demand from countries for more information on experiences and lessons learned about HSS by other countries.

### X *Transition arrangements from existing GAVI HSS support to the Platform*

4.25 The transition arrangements to the Platform are described in Annex 6. There are three distinct country groupings, each with slightly different ways of transitioning to improved alignment and harmonisation:

- *Countries already approved (or pending approval) for GAVI HSS, likely to end before end 2011.* If eligible, focus on readiness to receive Platform funding post 2011.
- *Countries already approved (or pending approval) for GAVI HSS beyond 2011.* It is worth considering better alignment and harmonisation of existing HSS support with country processes and cycles. These countries could be regarded as Track 1 countries, although the impetus to better align with country processes is NOT dependent on Global Fund or World Bank support and NOT dependent on being an LIC, as there are no new resources required. The processes will include taking part in annual health sector reviews, negotiating shared indicators and harmonised fiduciary oversight.
- *Countries which have never or unsuccessfully applied for GAVI HSS.* These countries would need to be at the start of their planning cycles and also be low-income to be eligible for any future GAVI HSS support.

All these transition arrangements entail a huge burden of work for the GAVI Secretariat.

#### *Risks*

There are clearly some significant **risks** in developing and implementing the Health Systems Funding Platform. These risks include overly high expectations as compared to the resources available; delays to countries

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receiving support as joint arrangements are finalized; relatively little new funding available; and agreement being possible in only a few countries about funding aspects of national health plans. A full risk and management analysis will be presented to the PPC in May (but see Annex 10, which was already presented to the PPC). An update will be provided to the June Board.

### *Timeline*

Please see Annex 10, which details what the process could be, but, in summary:

Ongoing. Implementation of joint workplan, particularly focusing on a communications strategy (by end April 2010) and further consultations

April/May/June – further country work for Track 1 – harmonisation of existing support. GAVI is the lead coordinator for this in the joint workplan.

April/May/June – further country visits: Ethiopia, Vietnam, Cambodia, Mali (for track 2), possibly others, dependent on country feedback.

18 May. PPC meeting. Update on progress, presentation of further work on allocations, and risk management.

16 /17 June. Board meeting – document presented depends on outcome of 20 April meeting.

### **Annexes – Available Upon Request**

The supporting annexes referred to in this paper are available to any board member upon request. If you would like to receive an electronic copy of the annexes, please email Kevin Klock at [kklock@gavialliance.org](mailto:kklock@gavialliance.org).

Annex 1: Summary of Cambodia, Ethiopia, Nepal and Vietnam Recent Visits

Annex 2: Consultations on Joint Platform

Annex 3: Joint Workplan with Timeline

Annex 4: Key Board and Executive Committee Decision Points

Annex 5: Recommendations: The HSS Evaluation & Tracking Study

Annex 6: Lessons Learnt from the HSS Task Team

Annex 7: Transition Arrangements to the Joint Platform for GAVI Eligible Countries

Annex 8: Preliminary Note on Allocating HSS Resource

Annex 9: Added Value of the Platform for the GAVI Alliance

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Annex 10: Risk Analysis and Mitigating Strategies

Annex 11: Challenges and Assumptions

Annex 12: Issues and Annexes Presented to the Board and PPC