FOR DECISION

At the meeting in June 2010, the Board made three decisions of relevance to the nature of the GAVI Alliance's continuing role in health systems. The Board endorsed:

1. The inclusion of Strategic Goal 2 "Contribute to strengthening the capacity of integrated health systems to deliver immunisation" as part of the approval of the GAVI Alliance Strategy 2011-2015;
2. "That the maximum share of funding for cash based programmes in a given proposal round will be 15-25%; and
3. "A new HSS resource allocation method whereby the maximum potential amount of funding would be based on an eligible country's total population and weighted against a graded gross national income (GNI) scale". This resource allocation formula would apply to any Health Systems Funding Platform grant going forward.

The Board also decided, by a majority vote, to "retain the notional US$ 179 million not yet expended from the original HSS window subject to availability of funds and in line with maintaining the appropriate balance between vaccine and cash programmes" but stated that the Board "shall revisit this decision at its November 2010 meeting based on further advice from the PPC as to what extent the maximum share of funding includes HSFP funding".

In Board discussions through 2009 and 2010 there has been an implicit agreement that all future GAVI support for health systems strengthening (HSS) would be provided as part of the Health Systems Funding Platform and, wherever possible, existing grants would be reconfigured to follow Platform principles. In that context the June Board minutes also noted that some countries are GAVI eligible but are not eligible for funding from the expanded IFFIm funds (i.e. they are lower middle income countries, not low income countries) but did not at that time make a decision.

The PPC at its October 2010 meeting addressed the question of whether, in the future, GAVI health system support should be offered only to low income countries and revisited the decision in relation to the notional allocation of US$ 179 million as requested by the Board.

The PPC recommends the following decision to be taken by the GAVI Alliance Board

- That HSS support is currently being offered to low income countries (LICs). Low-income countries will be funded from the Expanded IFFIm.
- The notional US$ 179 million from the original HSS window be returned to the balance of expected demand.

In relation to the first decision point, the PPC was in strong agreement that country eligibility
should aim to be consistent across all GAVI programmes. It stressed that the recommendation to restrict HSS support at this time to low income countries resulted from the current financial environment.

FOR DECISION

HSS Decision and Updates

1. Introduction

1.1 This paper and the subsequent Board discussion are intended to address the issue of how we decide the relative allocation between cash and vaccines. We will come back to the Board in June 2011 and the Executive Committee in September with the latest estimates, but the process should be settled during the 30 November - 1 December 2010 Board meeting.

1.2 Since April 2009, the World Bank, GAVI Alliance and GFATM, together with WHO, have been working on joint approaches to health systems strengthening (HSS) based on the Paris/Accra principles of greater aid effectiveness, which were also reflected in the International Health Partnership. This work is in response to the call by the High Level Task Force on Innovative International Financing for Health Systems to get 'more health for the money' - in part through establishing a Health Systems Funding Platform (HSFP).[1] The UK, Norway and Australia all agreed to provide funding specifically for this initiative.

1.3 Development of the Platform is a key activity under Strategic Goal 2 of the 2011-15 GAVI Strategy- *contribute to strengthening the capacity of integrated health systems to deliver immunisation.* A Task Team has been refining the draft Business Plan relating to SG2, and the Chair's summary is available in Annex 5 of the GAVI Alliance Business Plan 2011-2015 paper. The Platform deals with issues that are highly relevant to immunisation, including:

1.3.1 A focus on integrated health service delivery – clients accessing other services are also offered immunisation and vice versa.
1.3.2 Institutionalising service delivery – capacity to deliver services year after year is necessary if gains in immunisation coverage are to be sustained.
1.3.3 Equity

1.4 Health systems support through the Platform is now firmly in the implementation phase. This paper requests Board decisions on two outstanding issues - country eligibility for GAVI HSS support in the future and clarity in relation to how the decision and planning on the relative shares between vaccines and cash based programmes will be managed. An update on progress with the Platform is provided in Annex 2.

[1] Recommendation 9 from the meeting of the High Level Task Force, September 23, 2009: "Establish a health systems funding Platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies."

FOR DECISION

2. Country eligibility for GAVI HSS funding

2.1 Following the Board's decision on eligibility for GAVI funding in November 2009, there are currently 56 countries eligible for GAVI support given that they have an annual GNI per capita less than US$ 1,500. Of these 56 countries, 40 are low-income (GNI of less than US$ 995) and 16 are lower-middle income (LMIC; with a per capita annual GNI between US$ 995 and US$ 1,500.)

Table 1 – GAVI Country Eligibility

56 GAVI Eligible Countries	40 Low Income Countries (LICs)	GNI per capita less than US$995
	16 Low Middle Income Countries (LMICs)	GNI per capita between US$995 and US$1500

Note: This is based on the World Bank list (July 2009)

2.2 Though the Report of the High Level Taskforce on Innovative International Financing for Health Systems in 2009 does not specify Platform funding be limited to LICs (it does reference LICs), there has been an implicit assumption that the funding provided specifically for health system strengthening through IFFIm funding was intended only for low-income countries. This leaves open the question of GAVI country eligibility for new GAVI HSS support, and how much money should be made available in the financial demand forecasts to 2015.

2.3 Two options were put to the PPC in relation to eligibility for HSS, in the absence of specific Board policy:

Option 1 that HSS support is only offered to GAVI low-income countries (LICs)

Option 2 that HSS support be notionally offered to all GAVI eligible countries subject to funding availalbity and if necessary applying prioritisation criteria

2.4 The PPC discussed the advantages and disadvantages of both options. These are summarised in the table below.

Table 2 – Option 1 and Option 2

Eligibility for HSS	Advantages	Disadvantages
Option 1 – low-income countries only	• Lower cost • Focuses on poorest countries	• Introduces a new "eligibility list" • LMICs may perceive this as unfair and

		unexpected
Option 2 – all GAVI-eligible countries	• Consistent with overall GAVI eligibility policy • Reflects GAVI ethos of fairness	• Cost • Less targeted

2.5 The PPC decided to recommend to the Board that GAVI fund only LICs for HSS. However, it also noted that eligibility for GAVI HSS support should aim to be consistent across all GAVI eligible countries. The recommendation to restrict HSS support at this point in time to low income countries results from the current financial environment.

2.6 If the Board confirms the PPC's decision to only make funding available to 40 LICs the Secretariat will prepare a communications plan related to the transition and work with the Lower Middle Income countries to handle the "phase out" process from GAVI HSS support.

2.7 Table 3 below summarises the current situation for the 16 LMICs. Concerted efforts will have to be made for the 6 countries with funding ending in 2010/2011 to identify other possible funding. These are likely to be World Bank sources, possibly GFATM grants (for example Vietnam is discussing an HSS grant with GFATM), or bilateral sources. GAVI Alliance partners and donors will have a key role in these discussions.

Table 3 – HSS Grant Timelines

HSS grant	**Number of country grants**
HSS grant ending in 2010	2 (Pakistan, and Vietnam)
HSS grant ending in 2011	4 (Nigeria, Yemen, Sudan, Nicaragua)
HSS grant ending in 2012 or later	3 (Cote d'Ivoire, Cameroun, Senegal,)
No successful application for HSS support	6 (Djibouti, Guyana, Lesotho, Papua New Guinea, Sao Tome and Principe, Uzbekistan)
Total	**15** (India not included)

3. HSS and IRIS

3.1 **IRIS window.** One key process in taking forward HSS has been to ensure strong links with the new IRIS window (Incentives for Routine Immunisation Strengthening). The two windows are complementary – IRIS focuses on enhancing immunisation coverage and equity through a performance-based approach. IRIS will focus on helping countries with low immunisation coverage to achieve and sustain greater than 70% DTP3 coverage.

3.2 IRIS and the Platform are similar in that both seek to catalyse improvements in immunisation coverage and equity. However the Platform support is harmonised with other partners and has a longer-term focus on

the overall strength and capacity of the health system, whilst disbursing annually on the basis of demonstrated progress. In contrast, IRIS responds to the immediate need to support countries to raise their DTP coverage above 70% in order to meet the filter requirement for accessing GAVI support for some new and underused vaccines.

3.3 Options will be explored for linking the IRIS and HSS applications to ensure that they are fully consistent, with appropriate linkages and no duplication. Fourteen countries qualify for IRIS support - ten low-income and four lower-middle income countries.[2] Eligibility for IRIS support will be a key point in discussions with these 4 countries if the Board decides that they are not eligible for HSS support.

3.4 An important, and complementary component in GAVI's cash based support is the role of Civil Society Organisations (CSOs) in engaging in the policy debates at country level, in providing critical services, but particularly in the area of mobilising communities, and in advocacy for immunisation and introduction of new vaccines.

4. Projected GAVI HSS Funding in the context of the agreed relative share of resources between vaccines and cash based programmes

4.1 It was clear in the consultations and discussions during the development of GAVI's strategy for the period 2011-2015, and looking beyond, that the nature and extent of GAVI's role in health system strengthening was undoubtedly the issue where there was least consensus amongst board members. A number of decisions made at the June 2010 Board meeting have helped clarify key aspects.

4.2 As a result of this uncertainty, the financial demand forecasts in relation to HSS provided to the Board in June were based on the assumption that the amount of any new funding available for health systems was capped at a notional US$ 474 million. This was the amount likely to be generated through the earmarked funding to IFFIm. No additional funding beyond current HSS commitments was built into the GAVI financial forecasts provided at that time. However, the estimates did include current commitments of US$ 568 million, and US$ 179 million as the balance of notional demand for countries that were eligible for the original US$ 800 million window HSS support, but had not yet applied.

4.3 To understand the options facing the Board it is important to look at the application of the resource allocation formula HSS approved by the Board in June. The maximum potential funding per country is based on population weighted against a graded gross national income (GNI) scale. There is a minimum envelope of US$ 3 million so that very small countries do not receive an unreasonably small allocation. This model can be applied using a

[2] Papua New Guinea, India, Nigeria and Yemen.

defined resource envelope (in this case the notional income to be generated by the earmarked funding to IFFIm) or by calculating the maximum amount of funding available per country as per the agreed formula (without resource envelope).

4.4 Table 4 below shows the financial implications of the scenarios for the two options: either capped within the notional amount generated by the earmarked IFFIm funding or by the resource allocation formula which has a built in maximum amount for each country. These scenarios assume that all countries that are eligible to apply will do so when their current grants expire.

Table 4 – HSS Eligibility Scenarios and Financial Information

	Eligibility for HSS	**With cap 2010-5**	**Resource allocation formula, 2010-5 (without cap)**
Option 1	Low-Income Countries only	**US$370.8 million**	**$539.4 million**
Option 2	Low-Income Countries	US$370.8 million	US$539.4 million
	Low-Middle Income Countries	US$71.2 million	US$129.7 million
	All GAVI eligible countries	**US$442 million**	**US$669.1 million**

Note: The figures for the Low-Middle Income countries do not include India.

4.5 However, it should be clearly understood that the figures in Table 4 are not based on a country's expressed interest in applying for grants under Platform arrangements. They are the maximum amount that all eligible countries could apply for by applying the resource allocation formula to the IFFIm capped amount or by applying the resource allocation formula without a capped amount (defined resource envelope). The figures in Table 4 are therefore the upper limit scenarios and the maximum amount of funding GAVI can allocate according to GAVI policy (based on the June 2010 Board decision). Inevitably, actual funding requests and approvals will be less. See Annex 1 for the resource allocation to countries between 2010 and 2015.

Table 5 – Maximum Demand for New Funding for HSS in 2011 (Without Cap)

	Country	**Maximum Annual Funding as per GAVI Policy (US$ million)**	**Total Maximum Funding (four year grant) (US$ million)**
Completed, or completing current HSS grant	Ethiopia	24.5	98

No previous HSS application	Tanzania	3.2	12.8
	Zimbabwe	2.4	9.6
	Mozambique	1.8	7.2
	Comoros	0.6	3
Total Maximum New Funding 2011		**32.5**	**130.6**

Table 6 – Maximum Demand New Funding for HSS in 2012 (Without Cap)

	Country	**Maximum Annual Funding as per GAVI Policy (US$ million)**	**Total Maximum Funding (four year grant) (US$ million)**
Completed, or completing current HSS grant	Malawi	4.2	16.8
	Sierra Leone	1.5	6
	Kenya	3.1	12.4
	Niger	4.0	16
	DRC	32.1	128.4
	Burundi	4.3	17.2
	Afghanistan	3.0	12
	Madagascar	2.2	8.8
	Liberia	1.7	6.8
	Rwanda	1.1	4.4
	Zambia	0.9	3.6
	Lao PDR	0.6	2.4
Total Maximum New Funding 2012		**58.7**	**234.8**

4.6 Table 5 and Table 6 show the maximum amount of likely new funding for HSS support through the HSFP in 2011 and 2012, respectively. This is based on an indication of country demand and allocates resources to countries without using a defined cap.[3] Based on countries applying for four years grants (four years is currently the average length of an HSS grant), the total maximum demand for 2011 is US$ 130.6 million and for 2012 US$ 234.8 million. Overall, the likely demand for HSS from 2011-2012 is US$ 365.4 million. However, this is a maximum amount and will decrease according to a given resource envelope.

[3] This is based on current information available to Country Responsible Officers, grant utilisation rate and whether a country has previously applied for HSS support.

4.7 However, it is important to bear in mind that without introducing countries to the new Platform framework, it is difficult to predict when a country will apply for HSS support and the length of the grant that will be requested.

4.8 The recommendation of the PPC "to return the notional US$ 179 million from the original HSS window to the balance of expected demand" should be interpreted as a gesture of good will by those Board members most concerned to ensure that GAVI continues to meet its commitment to Strategic Goal 2, recognising that our financial management is better served by an integrated and comprehensive approach to grant commitments and financial forecasts, but on the understanding that the Board decision on the relative share between vaccines and cash based programmes will be honoured.

4.9 Addressing that commitment raises some quite challenging operational considerations and presents both opportunities and risks. Table 7 provides a useful overview of the projected balance between vaccine and cash-based programmes between 2010 and 2015. Annex 3 provides more detailed forecasting on relative share and issues. In summary, this annex suggest that the relative share of cash based support could range from 12% to 22% over the period 2010-2015 and account for approximately 15% averaged over the period 2010-2015.

Table 7 - Projected Balance Between Cash Based and Vaccine Programmes

	2010	2011	2012	2013	2014	2015	**2010-15**
Cash-Based	169	204	161	157	164	166	1,021
Vaccines	584	834	1,170	1,176	1,064	1,055	5,883
Total	753	1,038	1,331	1,333	1,228	1,221	6,904
Cash-Based as % of Total	22%	20%	12%	12%	13%	14%	**15%**

4.10 It should be noted that actual demand for both vaccines and cash based programmes may differ from the projections and/or the overall level of resources may be such that GAVI can only fund a proportion of that demand. These and other factors may cause the relative shares of vaccines to cash grants to differ from the figures provided in this paper. Another factor is that new vaccine proposals will remain on a rounds-based approach while HSS Platform proposals will be approved on a rolling basis throughout the year. In periods of anticipated resource constraints, a notional ceiling for cash based programmes (informed by projections) could be established at the beginning of a year to mitigate the risk of having over funded one area before the actual demand for both areas was fully known.

4.11 Notwithstanding uncertainties, the availability of demand forecasts gives confidence to doing away with the need to earmark funding for particular

forms of support. Doing so could help optimise the use if limited financial resources in a manner that responds to country demand to the maximum extent possible.

5. HSS oversight

5.1 Oversight within GAVI. The transition towards new forms of support for health systems is being overseen by the PPC and Board. The Board, PPC, and Executive Team all receive updates about health systems support. Starting on a pilot basis, a joint independent review body (with GFATM) could also begin work assessing new funding applications in the first half of 2011.

5.2 Management of the Platform. Platform design and implementation is managed primarily at country level. To help in coordination between the agencies at HQ level, a working group meets on a regular basis. Representatives from the GAVI Secretariat, the Global Fund, the World Bank and WHO comprise the working group, and meet on a bi-weekly basis to discuss Platform strategy and operations. External views are additionally provided by donors, CSOs and others through the IHP+ Executive Committee and other forums.

5.3 So far, this transition period for health systems support has been organised through the structures of the HSFP. However, this needs to evolve further. The existing IHP+ mechanisms and HSFP teleconferences will now be supplemented with quarterly telecon/video-conferences that involve more donors and CSOs. Practical implementation arrangements will be addressed through implementation of the Business Plan, with regular adjustments as needed.

6. Update on risks, monitoring and evaluation

6.1 It has become clear that GAVI needs to get the Platform processes to work in the short term. This is because GAVI is committed to replace its existing application and review procedures with Platform procedures with immediate effect (starting with pilots). In contrast, the first GFATM funding for health systems as part of the Platform is linked to the round 11 funding window (i.e. support will be approved at the earliest in late 2011).

6.2 Another difference is that GAVI is also attempting, as soon as possible, to channel all its health systems support through the Platform, whereas the GFATM will continue to allow applicants to integrate HSS funding requests into regular disease proposals and into funding requests based on a National Strategy Application. In addition, the Global Fund's business model is intrinsically more challenging to adapt to the Platform's aims than that of GAVI. The World Bank does not have to make any changes to the ways countries access funding as a result of the Platform, so these processes are

not relevant to them. These risks are being managed on an ongoing basis, but are something that the Board should be aware of.

6.3 A decision to not fund the 16 LMICs will require clear and unambiguous communication, with a tailored message for each country which would no longer be eligible for HSS funding.

7. Next steps

7.1 Regular briefings to the Board, EC and PPC will continue, as needed.

7.2 Finalising and distributing the full set of materials for countries – guidelines and form. (Final draft ready for consultation by December 2010)

7.3 Testing out both types of application, likely starting with Ethiopia (March 2011) for the application based on a national plan/strategy. Use of joint forms is to begin when possible.

7.4 Depending on the GAVI Board decision, a communication plan to be outlined for all countries – the 40 that would be eligible for HSS support, and the 16 LMICs that would not be eligible.

7.5 Provide the Executive Committee options for setting an initial financing envelope for 2011 to allow initial funding of applications through the Platform.