Report to the GAVI Alliance Board

16-17 November 2011

Subject:	**Performance Based Funding**
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Agenda item:	13
Category:	For Decision
Strategic goal:	SG2 - Health systems to deliver immunisation

Section A: Overview

1. Purpose of the report

1.1 The GAVI Alliance Board is requested to approve the recommendations of the Programme and Policy Committee (PPC), as described below.

2. Recommendations

2.1 At its meeting in September, the PPC recommended that the GAVI Alliance Board:

(a) Decide not to proceed with IRIS as a stand alone window of support;

(b) Request the Secretariat to roll out the Health Systems Funding Platform in accordance with the design summarised in Annex 1 of the report to the Board on performance based funding (Doc 12) starting in 2012 for countries to use as their existing GAVI cash support elapses.

3. Executive summary

3.1 Taking into consideration the Board discussion from July 2011, the PPC has endorsed an approach to link GAVI's cash support to immunisation outcomes. These recommendations are described in Annex 1.[1]

3.2 In summary, GAVI's cash support will be split into two different types of payments: fixed and performance. For the first year, participating countries will receive all funds from GAVI on a fixed basis, as an upfront investment in their national health strategy. After the first year, the fixed and performance payments will be provided annually as long as the necessary conditions have been met. In order to ensure that countries with lower immunisation coverage

[1] The task team report and detailed draft guidelines as presented to the PPC are available from the Secretariat upon request.

at baseline receive a higher proportion of payments on a fixed rather than performance basis, GAVI will classify countries into three categories depending on their immunisation coverage rates.

3.3 With the exception of the new vaccine introduction grants and potentially support to civil society organisations (CSOs),[2] the PPC recommended that all of GAVI's cash support to countries should be included in this approach and delivered through the Health Systems Funding Platform (HSFP). However, it is recognised that a one-size-fits-all approach to cash support will not meet the needs of all of the diverse countries that GAVI supports. For some countries, such as fragile states, GAVI needs to retain flexibility in how GAVI's cash support is designed and applied. The PPC has thus also requested that the Secretariat develop a policy that clearly defines fragile and under-performing countries and the GAVI Alliance's approach to supporting them for presentation to the Board in 2012 following PPC review. In addition, there is a recognised need for a tailored approach to supporting large population countries, such as India and Nigeria.

3.4 Of note, the amount of money that very high coverage countries can receive is capped at the level of the country's allocation, but lower coverage countries can receive additional funding depending on the number of children immunised.

3.5 Given that the quality of country administrative data is of critical importance in this approach, the PPC noted that GAVI should consider increasing its investments in efforts to improve data quality and means of verification of reported data. This could include investing in independent household surveys to verify country administrative data and other methods for improving the measurement of coverage, such as through the use of biomarkers. As such, exploratory work in these areas is included in the 2012 business plan.

4. Context

4.1 In December 2010 the Board requested the Secretariat to establish mechanisms to ensure that GAVI funding through cash-based programmes is designed to have a reasonable and demonstrable impact on immunisation programmes in the context of integrated service delivery, and that immunisation coverage is a credible outcome indicator for these activities. They also requested the PPC to provide the Board with a comprehensive approach on cash-based support to countries including a strategy for countries that are below 70% DTP3 coverage or have stagnating or declining coverage. At the same time, the Board requested that the PPC define the implementation of a pilot for an incentive approach for routine immunisation strengthening (IRIS).

[2] The current window of support for CSOs is being evaluated and recommendations for next steps on CSO support will be brought to the PPC in May.

4.2 In response to these requests the PPC created two task teams – one focused on development of the IRIS pilot and the other to review GAVI's approach to cash based support. The IRIS Pilot Task Team was chaired by Cristian Baeza, the GAVI Board member representing the World Bank. The Task Team met on five occasions between May and September 2011 through a combination of in-person meetings and teleconferences.[3]

4.3 In July, the Board reviewed the PPC's recommendations on cash based support. They requested the Secretariat continue working with partners to rollout the Health Systems Funding Platform (the "Platform") in a manner which ensures that immunisation outcomes are clearly articulated in accordance with country demand, including assessing and addressing associated risks. They also requested the Secretariat to develop options for performance incentives for GAVI's cash based support through the Platform and endorsed transitioning arrangements from existing GAVI Health Systems Strengthening (HSS) support to the Platform.

4.4 In light of the July discussion and in consultation with the chair of the PPC, the IRIS task team shifted its focus from developing IRIS as a standalone window to making recommendations about how all of GAVI's cash support[4] could be delivered in an integrated manner through the HSFP with a clear linkage to immunisation outcomes.

4.5 In September 2011, the PPC reviewed the recommendations from the Task Team and recommended that the Board approve the recommended design, for roll out starting in 2012.

4.6 In response to comments from the PPC, the Secretariat has added to this paper considerations related to increasing investments in improving administrative data quality and means of verification as well as an explicit statement indicating that in the case of force majeur a country's grant agreement and related disbursement conditions may need to be modified.

5. Next steps

5.1 If endorsed by the Board, the GAVI Secretariat will work with countries and implementing partners to finalise programme design and guidelines. The approach will be gradually rolled out to countries as their existing GAVI cash support elapses.

[3] Other members included Joan Awuno-Akaba (Future Generations, Ghana), Amie Batson (USAID), James Droop (DFID), Rena Eichler (Broad Branch Associates), Peter Hansen (GAVI Secretariat), Par Eriksson (GAVI Secretariat), Lidija Kamara (WHO), Rama Lakshminarayanan (World Bank), Ingvar Theo Olson (NORAD), Violaine Mitchell (Bill & Melinda Gates Foundation), and Mohammed Pate (Federal Ministry of Health, Nigeria).

[4] The new vaccine introduction grants are excluded. The inclusion of GAVI's support for civil society organisation is pending the Board's policy decision on how GAVI engages and supports civil society.

5.2 The Secretariat will develop a policy that clearly defines fragile and under-performing countries and the GAVI Alliance's approach to supporting such countries to be presented to the Board in 2012 following PPC review. For fragile countries and other countries warranting special consideration, alternative funding agreements will be specifically negotiated in order to provide a more tailored approach to GAVI's cash support. The specific payment design, performance indicators and means of measurement and verification will be decided jointly with countries on a case-by-case basis and documented as part of the grant agreement between GAVI and the country.

5.3 The Secretariat will continue its work with partners to finalise a revised data quality assessment tool for piloting in early 2012 and accelerate its exploratory work on innovation in coverage estimation, including the possible use of biomarkers to verify reported administrative data in selected cases.

5.4 The experience with the gradual rollout in 2012 will be carefully monitored and evaluated to generate lessons learned to help inform the design for countries that will be applying for new cash support in 2013. Based on the cycle of GAVI's cash grants to countries, it is expected that in 2012, 2013, and 2014 approximately 13 additional countries per year will be applying for new cash support from GAVI.

6. Conclusions

6.1 This recommended approach clearly articulates how GAVI provides cash support to contribute to immunisation-specific results, as defined in GAVI's mission and strategic goals. A consolidated approach to cash based support reduces the number of grants and associated transaction costs, while providing flexible support with a focus on immunisation outcomes.

6.2 The recommended approach enables the GAVI Alliance to address equity through its cash support to countries on a pilot basis, while strengthening routine systems that will be used to deliver new and underused vaccines in addition to existing vaccines.

Section B: Implications

7. Impact on countries

7.1 Future cash support for health systems delivered through Platform mechanisms will be better aligned with national plans, priorities and fiscal cycles, and—assuming that Platform partners are able to go forward in coordinated fashion — will use harmonised procedures for financial management, monitoring and evaluation, reporting and joint annual reviews. Transaction costs will be reduced for countries in the long term by reducing the number of grants and providing flexible support focusing on outcomes. Platform partners will use a common monitoring framework that includes the immunisation indicators GAVI needs to track, as well as common fiduciary

arrangements. Joint missions and common assessments will be conducted as appropriate to reduce transaction costs and the burden on countries.

7.2 Under the recommended design, countries will have to meet the conditions specified in Annex 1 in order to access funds from GAVI. All countries will have a proportion of their cash support envelope at risk. This is a fundamental change from GAVI's previous HSS window, but is similar to GAVI's ISS window. The payment rules are transparent and predictable, but there is no guarantee of receipt of funds by countries unless performance conditions are met.

7.3 Depending on the number of children they immunise, countries in categories B and C can receive additional funds and thus surpass their indicative allocation.

8. Impact on GAVI Stakeholders

8.1 Delivering GAVI's cash support through the Platform will contribute to improved harmonisation and alignment. The Platform has been designed specifically to improve the way external funders support countries to strengthen their health systems, in alignment with jointly assessed national strategies and the principles set out in the Paris Declaration on Aid Effectiveness.

8.2 The introduction of a performance based element to GAVI financing will have to be clearly explained to countries and both the Secretariat and Alliance partners should be available to facilitate where necessary. The transparent and predictable performance conditions will help bring clarity to all GAVI stakeholders on the immunisation results that need to be achieved for payment conditions to be met.

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

9.1 Technical assistance to countries to improve immunisation outcomes is included as a costed component of the GAVI Business Plan for 2011-15. The Business Plan also includes financing to strengthen country M&E systems (WHO/Health Statistics and Informatics lead) and to address discrepancies between administrative coverage and WHO/UNICEF estimates (WHO/Immunization, Vaccines and Biologicals lead). Finally, funding has been allocated for exploration of options for GAVI to increase engagement and investments in independent verification of coverage, such as through household surveys or biomarker prevalence studies.

10. Risk implications and mitigations

10.1 Cash programmes entail inherent risks. Risks include misappropriation, other forms of financial mismanagement, dependence on external funds and substitution of government investments in health. In order to reduce the risks surrounding financial mismanagement, GAVI's cash support will be delivered in compliance with the current Transparency and Accountability Policy (TAP).

All financial control elements of TAP are binding on the recommended approach described in Annex one, including the requirement for certified financial statements to be submitted annually. With regards to jointly financed programmes, risks may be further mitigated through joint (fiduciary) oversight with other development partners and joint remedial action in case of misuse. Improved harmonisation with other donors and alignment with country procedures, including use of commonly agreed monitoring and fiduciary frameworks, is intended to ultimately decrease risk related to misuse of funds and increase GAVI's ability to track performance.

10.2 There is a risk that GAVI's disbursements on cash programmes may be lower than the Board mandated range of 15-25% of total disbursements to countries. For a variety of reasons, the experience with cash programmes to date has been that the actual amount disbursed has been substantially lower than the indicative or absolute maximum amount that could be disbursed (some countries do not apply right away, some do not have their proposals recommended for approval, some do not meet TAP requirements, some have low cash utilisation rates, some do not meet conditions for performance payments, etc). The recommended programme design has a projected average annual disbursement of approximately US$ 200 million, which aligns with the Board's decision to spend 15-25% of GAVI's total disbursements on cash programmes. Disbursements will be carefully tracked over time.

10.3 A specific risk that will need to be addressed for countries is challenges with funding flows and delays in disbursements, as experienced with the current GAVI HSS support. This is an inherent risk across all cash programmes and is not unique to the approach described in this paper. This risk to countries can be reduced through contributing to pooled funding and jointly financed national health strategies with governments and other development partners as these can help decrease dependence on any one donor.

10.4 As the GAVI Alliance, where possible, will use country administrative data to track progress on performance indicators to which GAVI's payments are linked, the lack of robust country administrative data poses a significant risk. Payments may be disbursed based on performance data that are discovered later to be inaccurate. In order to mitigate this risk, WHO/UNICEF estimates will be used to verify country reported data. For those countries where there is a discrepancy with WHO/UNICEF estimates, GAVI will request that they produce a plan for assessing and improving their administrative data system and the GAVI Alliance will provide technical and financial support for such plans as appropriate. Another means of mitigating risk is to increase GAVI's investments in independent household surveys to verify country administrative data and to inform the production of the WHO/UNICEF estimates. In 2012, the GAVI Alliance will explore options for investing in innovation to improve the measurement of coverage, such as through the use of biomarkers.

10.5 One specific measurement challenge relates to the fact that under the recommended design, payments may be made in the case of even small gains in coverage. Under the ISS window, countries can receive reward payments—

albeit very small payments—for vaccinating a single additional child, even if coverage is stagnant or decreasing. Under the recommended design as described in Annex 1, countries must increase coverage in order to receive performance payments, so countries with stagnating or decreasing coverage would not receive performance payments. Countries that increase coverage by a single percentage point would, however, qualify for a performance payment, even though available measures of immunisation coverage are not sufficiently precise to determine whether a reported one percentage point increase in coverage is a true increase in coverage as opposed to measurement error. This could pose a significant reputational risk for the GAVI Alliance. This risk is, however, small in monetary terms since the size of performance payments is proportional to increases in coverage and children immunised—small increases in coverage and children immunised would therefore lead to small performance payments. This risk could be further mitigated by introducing additional checks and balances that use household survey data over longer time periods to assess whether the reported increase in coverage over the time period corresponding to the cohorts measured by the different surveys is supported by the independent survey data.

10.6 One specific risk that is decreased with the recommended approach as described in Annex 1 is the risk that GAVI's current support lacks a clear linkage to immunisation outcomes. In the proposed approach, the GAVI Alliance gains assurance that its investments are explicitly linked to increases in immunisation coverage and equity.

11. Legal or governance implications

11.1 At present, further to the GAVI Alliance Transparency and Accountability Policy and following a financial management assessment, GAVI negotiates an aide memoire with a country that set outs the agreement reached on financial management arrangements of GAVI's cash based support in that country. Where a joint financing mechanism is used for GAVI's cash based support in a country, GAVI needs to agree on the arrangements with partners participating in the joint financing mechanism and the country. Similarly, with the implementation of support to national health strategies, GAVI will also likely, but not necessarily, be a signatory of joint financing agreements with development partners and countries.

11.2 The Secretariat is currently reviewing its grant arrangements with countries, including for cash based support, with the dual aims of simplifying and harmonising those legal arrangements and minimising fiduciary risks to GAVI funding.

12. Consultation

12.1 The recommendations in Annex 1 were developed by the IRIS Pilot Task Team. The Task Team brought together a wide group of stakeholders including Board and PPC members, representatives from the CSO and implementing country constituencies and other Alliance Partners.

12.2 The first country consultation was held with participants at a Sub-Regional Working Group for Central and West Africa in Abidjan on 25 August 2011. The feedback was shared with the Task Team. Prior to the PPC meeting, a consultation was conducted with the developing country constituency members who sit on the Board and PPC. In-country consultations have been held with Ethiopia and Rwanda; additional consultations are planned with 3-4 additional countries.

12.3 It is recognised that additional consultations with countries are essential and the Secretariat has highlighted this as a priority moving forward. As such, the Secretariat has developed a systematic plan which is currently being implemented.

13. Gender implications / issues

13.1 GAVI's cash support will be delivered in accordance with the GAVI Alliance Gender Policy adopted in 2008. As cash support will be delivered under the Platform, country ownership and alignment will be promoted with regards to ensuring gender issues are appropriately addressed.[5] Countries will be actively encouraged to incorporate gender indicators and gender disaggregated data within their M&E plans and review processes, including Joint Assessment of National Strategies (JANS) and annual health sector reviews.

14. Implications for the Secretariat

14.1 A comprehensive approach to GAVI's cash based programmes should in the long term reduce the administrative load on the Secretariat through reducing the number of windows of support. However, in the short term, there will be an additional administrative load placed on the Secretariat for regular dialogue with Platform partners and countries as the cash support parameters and processes are developed and implemented.

14.2 Over the medium to long term, the design recommended by the PPC will be easier for the Secretariat and Alliance partners to manage than the existing HSS window. Because it has explicit conditions for disbursement of funds that are linked to results, the new approach has a clear and explicit structure that can be managed by countries and the GAVI Alliance alike.

14.3 The Secretariat will work closely with all countries and implementing partners to ensure that any confusion regarding process issues or the various bridging mechanisms going forward is clarified. Significant attention needs to be paid to ensure careful communication and consultation with countries regarding the transition to the new cash support approach.

[5] See section 1.4.3 of the GAVI Alliance Gender Policy.

Annex 1: Summary of design recommended by the PPC

a) GAVI's cash support will be split into two different types of payments: fixed and performance. For the first year, countries will receive all funds from GAVI on a fixed basis, as an upfront investment in their national health strategy. After the first year, the fixed and performance payments will be provided annually as long as the necessary conditions have been met.

b) In order to ensure that countries with lower immunisation coverage at baseline receive a higher proportion of payments on a fixed rather than performance basis, GAVI will classify countries into categories, as follows:

Category		Fixed payment	Performance payment
A	≥90% DTP3 coverage at baseline	20% of total indicative envelope received each year as a fixed payment	40% of indicative envelope for maintaining or increasing DTP3 coverage and the remaining 40% for ensuring that 90% of districts have ≥80% DTP3 coverage
B	70-89% DTP3 coverage at baseline	40% of total indicative envelope received each year as a fixed payment	If DTP3 coverage increases, $20 per additional child immunised with DTP3; plus $20 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases
C	<70% DTP3 coverage at baseline	60% of total indicative envelope received each year as a fixed payment	If DTP3 coverage increases, $20 per additional child immunised with DTP3; plus $20 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases

c) For category B and C countries with shrinking birth cohorts, an adjustment will be applied to the payment calculation formula in order to avoid penalising them.

d) GAVI will not attach conditions to the use of performance payments, with the exception that payments should not be used for GAVI's co-financing requirement.

e) The equity component will first be piloted with category A countries to see how well this payment element works; if the experience with very high coverage countries indicates that it is feasible, consideration will be given to introducing the equity component for all countries in the future.

f) Consistent with the Board adopted principles of the Health Systems Funding Platform, GAVI will use country M&E systems and administrative data to track performance indicators where possible. WHO/UNICEF estimates will be used as a check and balance for country administrative data. Countries lacking robust administrative data systems should be given the opportunity to use WHO/UNICEF estimates to determine performance payments on a temporary basis, while actions are taken to strengthen country systems.