



Report to the GAVI Alliance Board

12-13 June 2012

Subject:	Programme update: country programmes
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Agenda item:	B
Category:	For Information
Strategic goal:	SG1, SG2, SG3

Section A: Overview

1. Purpose of the report

- 1.1 To update on implementation of GAVI country programmes since reporting to the Board in November 2011.

2. Recommendations

- 2.1 This report is for information.

3. Executive summary

- 3.1 Good progress is being made in India and Nigeria. Pentavalent vaccine has now been introduced in two states in December 2011 in India and in January 2012 GAVI received a request to scale-up to an additional six states. Nigeria's National Vaccine Summit in April has focused high level attention on the phase-in of pentavalent and pneumococcal vaccines. This will be supported by reprogramming of GAVI HSS and ISS funds (up to \$60m in total) and targeting of potential new funding (to the tune of US\$ 40 million) until the country graduates.
- 3.2 Alliance partners are working closely with DRC, Ethiopia and Pakistan to support them to manage significant implementation challenges related to introducing and sustaining new vaccines. DRC paid its 2010 co-financing arrears in May 2012 and intends to pay the 2011 amount by June 2012.
- 3.3 In February 2012, WHO, UNICEF and the Secretariat reviewed progress on development of Alliance action plans to support countries achieve and maintain DTP3 coverage above 70%. WHO will prioritise work in Chad, DRC and Uganda and finalise plans in Q3 of 2012.

- 3.4 The IRC noted improved quality of the HSFP applications it reviewed in February 2012. This was the result of intensive technical assistance that WHO provided to countries with the support of the Secretariat. The Technical Advisory Group for Health System Strengthening (TAG-HSS) to be chaired by Dr Anders Nordström and reporting to the CEO has been established and draws on HSS expertise from across Alliance partners, in-country experts and individuals with technical expertise. The TAG-HSS will convene in June to agree terms of reference.
- 3.5 The focus across the Alliance is increasingly on assessing and supporting country readiness to introduce and sustain new vaccines into a country's routine immunisation programme. This includes ensuring that WHO/UNICEF technical assistance and GAVI HSS investments target immunisation bottlenecks. The Secretariat is strengthening its focus on stewardship of GAVI resources in partner countries.

4. Context

SG1 - Accelerate the uptake and use of underused and new vaccines

- 4.1 The New Vaccine IRC met in February 2012 and recommended approval of 14 proposals (7 for PCV, 6 for rotavirus vaccine and 1 for pentavalent) and approval with clarification of 4 proposals (2 for PCV, 1 for rotavirus vaccine and 1 for pentavalent). The IRC recommendations were endorsed by the Board in April 2012. A summary of IRC recommendations is provided at Attachment 1.
- 4.2 Based on 2010 WHO/UNICEF coverage estimates, 12 countries have DTP3 coverage under 70% - Afghanistan, CAR, Chad, DR Congo, Guinea, Haiti, Mauritania, Nigeria, PNG, Somalia, Uganda and Yemen. In February 2012, WHO, UNICEF and the Secretariat noted slow progress on development of Alliance action plans to support countries achieve and maintain DTP3 coverage above 70%. WHO agreed to prioritise work in Uganda, Chad and DRC. Action plans will be finalised in Q3 of 2012.
- 4.3 Progress is being made following the Board discussion in November 2011 relating to development of targeted approaches in India and Nigeria.

India

- 4.4 India is demonstrating a new vigour in its commitment to strengthening its immunisation programme. Pentavalent vaccine has now been introduced in two states and GAVI has received a request for scale-up to an additional six states. There is increasing demand from remaining states to also introduce. India has signaled that once the funding committed by the Board has been used, it will fund a full national roll-out. This would mean GAVI's funding has catalysed a critical introduction with significant public health impact and in a cost-effective way. A paper to the Board on the proposed approach to the development of a customised strategy for India has been prepared separately.

Nigeria

- 4.5 Nigeria is showing increasing commitment to immunisation. The National Vaccine Summit was successfully organised in mid-April with high level attendance and the country is phasing in pentavalent vaccines in 13 + 1 states from 2012 and PCV in 2013. 2011 came with severe stock outs of DTP and BCG vaccines and the problems spilled over into 2012. However, the Ministry of Health has been able to secured government funding for basic vaccines up until April 2013 and the problems will hopefully be resolved with the introduction of pentavalen vaccines in 2012. Based on recommendations of the Nigeria Task Team reprogramming of the current HSS and ISS grants (US\$ 60 m in total) and targeting of potential new funding until the country graduates from GAVI support has commenced and is expected to be finalised by August 2012. Nigeria puts a lot of efforts into polio eradication and is struggling to integrate polio eradication activities with routine immunization services. A Presidential Task Force has been established and an emergency action plan is being rolled out.
- 4.6 Some other countries are facing significant implementation challenges. These challenges, and the Alliance response, are highlighted below.

DRC

- 4.7 The new government shows promising signs of being committed to fixing the myriad of problems that the country is facing. There are positive developments with regards the DRC's ability to meet its co-financing obligations.
- 4.8 DRC has potentially an excess of up to 565,000 doses of pneumococcal vaccine because DRC had not paid its 2010 co-financing arrears for pentavalent and yellow fever vaccine and consequently was not approved to expand PCV introduction in 2012 to additional provinces.
- 4.9 In May the Government paid its 2010 co-financing contribution of \$1.2m however it remains in default for 2011. The Ministry of Health, with the support of in-country partners has identified a fifth province where they would like to roll out PCV. However expansion of PCV introduction in additional provinces will first take into account the EPI Review which was completed in April and an evaluation of the impact of the introduction of the pneumococcal vaccine in the first four provinces.
- 4.10 The EPI Review highlighted the need to strengthen cold chain logistics as well as the Immunisation Programme's capacity to deliver vaccines. Alliance partners also convened in April to understand how the PCV overstock position occurred in DRC and to consider lessons learned. There was agreement that GAVI needs to review country readiness in the period between approval and vaccine introduction as well as strong monitoring following introduction. This will be critical to ensure the success of other new vaccine introductions.
- 4.11 There are many complex and inter-related issues that are impacting on the ability of DRC to deliver a functional immunisation programme. The Board

recognised this at the December 2011 meeting when it asked the Secretariat to work with partners to develop a sustainable approach to immunisation financing and delivery. A new government in DRC is only now beginning to settle which has delayed in-depth engagement, however other related analysis has been undertaken. A temporary task team of Ministry of Health, Alliance and development partners has been established at country level under the leadership of the government and will begin work to develop a tailored approach for GAVI support to DRC similar to the approach being taken in Nigeria.

Ethiopia

- 4.12 Ethiopia requested introduction of rotavirus vaccine from June 2012. Ethiopia's application was based on 2010 DTP3 coverage of 86% which contrasts markedly with estimated coverage of 37% by the Demographic and Health Survey (DHS) carried out in 2011. UNICEF and WHO are supporting the Government to conduct a follow-up coverage survey to clarify the current coverage figure. The DHS coverage result raises questions of doses required. This is particularly important in a situation of supply constraint.
- 4.13 A total of 5.4 million doses of rotavirus vaccine were approved for 2012. However vaccine supply constraints mean that GAVI may not be able to meet the country's full request. Options currently being discussed with Ethiopia include: i) postponing the introduction until late 2013 when supply is confirmed; or ii) very limited introduction starting late 2012.

Pakistan

- 4.14 An Alliance mission to Pakistan in April found that clarity is beginning to emerge regarding the impact of devolution of the Federal Health Ministry on the management of the Immunisation Programme. The Government has been preparing to introduce PCV nationally from July 2012 and is confirming roles and responsibilities between the Federal and Provincial levels of government in the new devolved environment.
- 4.15 Government and partners however recognise that the presence of endemic polio reflects underlying weakness in the EPI programme in some provinces. The Government considers that the introduction of PCV can help focus attention to strengthen the routine programme, but it also understands the need for a cautious approach to introduction. GAVI is discussing with Government a proposal to support a two-phase rollout of PCV10 from July 2012, starting with Punjab and followed with a national scale-up from 2013. The national scale-up would be preceded by a Post Introductory Evaluation in Punjab and would also be subject to the assessment of at least two additional monitoring missions by Alliance partners. Government and the Alliance need to be confident that additional provinces have the capacity to successfully introduce the new vaccine.

Mali

- 4.16 Following the military coup in Mali in March 2012, a new Minister of Health has been appointed but the situation remains challenging. GAVI has written to the

EPI focal point in the Ministry of Health advising that GAVI has temporarily suspended cash programmes. Two thirds of the country is not accessible for provision of service delivery. UN agencies and CSOs are providing humanitarian support to these regions. UNICEF/SD has postponed all vaccine shipments to the country. GAVI-supported vaccines in Mali includes pentavalent, pneumococcal and yellow fever.

Guinea Bissau

- 4.17 A military coup took place in Guinea Bissau in April. Political parties haven't reached any consensus on the way forward. All civil servants are on strike requesting the reestablishment of a legal constitution. No Government is in place and no salaries have been paid since April. UN agencies are mobilising their effort to give incentives to staff in order to ensure basic humanitarian activities.
- 4.18 GAVI has not sent a suspension letter to the Ministry of Health as the country has currently no unspent cash and there is no immediate risk for GAVI funds. UNICEF/SD is following up with the country on vaccine shipments. The EPI programme has enough stock of vaccines for the next three months. The vaccine programme in Guinea Bissau includes penta and YF.

SG2 – Contribute to strengthening the capacity of integrated health systems to deliver immunisation

- 4.19 Since the November 2011 Board meeting, the Secretariat has reinforced an understanding among partners that GAVI health system strengthening programmes demonstrate a strong link with immunisation outcomes. The interdependence between Strategic Goal 1 and 2 will be reflected not only in future health system strengthening programmes funded by GAVI, but also in the current portfolio of HSS grants.
- 4.20 GAVI participation in the Joint Annual Review (JAR) for Nepal confirmed that harmonisation of GAVI HSS support with other development partners and alignment with the national health strategy is feasible and effective. It demonstrates that the grant renewal decision can be better informed by the outcomes of the JAR as opposed to the GAVI's desk based Annual Progress Report (APR).

Snapshot of the current HSS portfolio

- 4.21 As of March 2012 there are 54 active health system grants under implementation. The total portfolio of approved HSS grants is \$442 million. About 80% of this amount (\$358 million) is already disbursed. 11 countries out of 54 (Burkina Faso, Ethiopia, Georgia, Kenya, Kyrgyzstan, Lao PDR, Malawi, Nicaragua, Rwanda, Vietnam and Yemen) will have completed grant implementation in 2012, as they have fully disbursed the committed amount.
- 4.22 The disbursement rate has been improved by the number of FMAs completed, thus reducing the proportion of countries delayed because of FMAs by 24.48% against the total number of HSS countries. In 7 of 16 countries (43.75%)

where FMAs are pending, the process is in the last step of finalising the Aide-memoire.

- 4.23 At this point 12 HSS countries with FMA Activity demonstrate disbursement delays of various degrees. Non-disbursement is due to factors including pending completion of a Financial Management Assessment (FMA) before disbursement of the 1st tranche (31%), including pending completion of the FMA due to important control deficiencies revealed by the FMA or proof of misuse (44 %). The remaining 25% did not reveal serious concerns and disbursement will not be held pending the signature of the Aide-memoire.

New grant applications

- 4.24 Between September 2011 and June 2012, GAVI received 13 new HSFP applications.
- 4.25 Seven HSFP applications submitted in 2011 were reviewed by the HSFP IRC in February 2012. Four out seven were approved during the first round of review. Three were recommended for resubmission. The IRC recommendations were endorsed by the Board in April 2012.
- 4.26 Six new HSFP applications submitted in 2012 were reviewed in May 2012 together with three applications that were resubmitted following the February review. From these nine applications five were approved and four were recommended for resubmission. The results of the May HSFP IRC will be tabled at the July AFC and EC meetings for endorsement. Programmatic and procedural recommendations of February and May HSPF IRCs are at Attachment 1.
- 4.27 The HSFP IRC highlighted an improvement in the quality of health system strengthening proposals. The proposals demonstrated greater focus on immunisation-specific aspects of health system performance. Linkages between objectives and interventions were more coherent. There was an overall improvement in M&E framework and indicators (though from a low base – see 4.29), as well as enhanced engagement of the Health Sector Coordinating Committee (or equivalent) at country level. Countries were able to better demonstrate linkages with other external funding sources.
- 4.28 The improvement in the quality of HSFP applications is a result of strengthened technical assistance that WHO provided to countries with stewardship from the GAVI Secretariat. Between November and December 2011, the GAVI Secretariat conducted four teleconferences with WHO regions to clarify programmatic and procedural questions for partners. In November 2011, WHO, with the support from the Secretariat, conducted a peer review workshop in Harare for AFRO countries. The workshop provided critical review and guidance relating to country applications. The IRC acknowledged that such intensive work with countries during the proposal preparation was a commendable practice.
- 4.29 Some of the key weaknesses that remain to be addressed in country applications are: insufficient demonstration of sustainable plans for maintaining

cold chain infrastructure to be acquired with GAVI support; variable unit costs and questionable cost-effectiveness of interventions/investments proposed for GAVI support; weak monitoring and evaluation frameworks; insufficient focus on upstream systemic actions and greater reliance on downstream non-strategic activities. The quality and effectiveness of technical assistance received by the countries from the Alliance partners needs to be improved.

- 4.30 During the third quarter of 2012, the Secretariat plans to revise the HSFP application forms. This is motivated by several factors, including the Global Fund's decision to suspend HSS funding, and the need to further simplify the application process while sharpening the focus on outcomes.

Strengthening GAVI's HSS Portfolio

- 4.31 In February 2012 WHO and the Secretariat organised a three day workshop to review GAVI HSS country programmes and to develop a strategic and operational plan of engagement with countries around HSS. The workshop produced a detailed work-plan which will guide WHO – GAVI collaboration during 2012 and beyond.
- 4.32 The Secretariat has established an interagency Technical Advisory Group for Health System Strengthening (TAG-HSS) to be chaired by Dr Anders Nordström reporting to the CEO. The TAG will meet in June 2012 to finalise its Terms of Reference and in September to agree a work plan. The TOR of the TAG-HSS is at Attachment 2.

SG3 – Increase the predictability of global financing and improve the sustainability of national financing for immunisation

- 4.33 At the end of 2011, all countries except Angola, CAR, DRC and Togo, fulfilled their 2011 co-financing commitment. Angola has had challenges meeting its co-financing commitment due to recent changes in government procedures for overseas electronic funds transfer. CAR is working with the WHO regional focal point and UNICEF to meet its co-financing commitment. Togo paid its co-financing obligation in February 2012 and is no longer in default.
- 4.34 In May DRC paid a co-financing contribution of \$1.2m and is no longer in default for 2010. The country remains in default of the 2011 co-financing requirement (\$2.3m). The Government has advised that it intends to pay another tranche of \$1.4m for 2011 co-financing before the end of June 2012.
- 4.35 The total amount co-financed by the 56 countries in 2011 was \$33 million. This is equivalent to 7% of the GAVI financial support to them. In 2011, 22 countries co-financed at a higher level than the GAVI minimum.
- 4.36 In December 2011, the Immunisation Financing and Sustainability (IF&S) task team agreed on priority countries and work plan deliverables for 2012 as well as a monitoring framework to oversee country progress. Visits to Congo Republic, Democratic Republic of Congo and Republic of Moldova, have already been completed in 2012. During the visits to Congo Republic and Republic of Moldova specific country action plans to support the graduation

process were agreed. The purpose of the visit to Democratic Republic of Congo was to collect financial information in relation to health and immunisation that fed into a corresponding country assessment, which will inform the next country visit. Co-financing issues will be a critical component of a country visit by the multi-partner task team when the new DRC Government is established.

5. Conclusions

- 5.1 Efforts are intensifying across the GAVI Alliance to support countries to successfully introduce new vaccines in 2012 and to monitor ongoing vaccine management. This is linked to closer monitoring of HSS programmes and ensuring investments are targeted at addressing constraints to improved immunisation outcomes. The focus across the Alliance is on supporting and improving country readiness to introduce and sustain new vaccines into a country's routine immunisation programme. This includes ensuring that WHO/UNICEF technical assistance and GAVI HSS investments target immunisation bottlenecks.

6. Next steps

- 6.1 Specific strategies are required for a number of countries to address critical weakness in their immunisation programme. This includes improving vaccine management, increasing effectiveness of HSS programmes, and/or initiating country financing strategies. Specific actions for the next six months include:
- Working with the countries to prepare action plans for Uganda and Chad that address constraints to achieving DTP3 coverage above 70%. (Work on DRC will be in the context of the task team that has been established to develop a broader country strategy.)
 - Agree vaccine implementation strategies and monitoring plans for introductions in DRC, Ethiopia and Pakistan.
 - Prepare action plans for India and Nigeria that target GAVI assistance to specific country-needs.
 - Convene the first meeting of the interagency Technical Advisory Group for Health System Strengthening.
 - Develop operational guidelines for implementation of Performance Based Financing (PBF).
- 6.2 Where appropriate this work will be integrated with the country-by-country policy development process.

Section B: Implications

7. Impact on countries

- 7.1 Around 20 new vaccine introductions are expected in 2012. A number of introductions are in countries with DTP3 coverage under 70% and with weak

immunisation and health systems. The proposed close monitoring of new vaccine introductions by GAVI partners such as that planned in DRC, Ethiopia and Pakistan may result in additional demands on government and will need to be managed carefully.

8. Impact on GAVI Stakeholders

- 8.1 Efforts to develop country action plans; ensure country readiness to introduce and monitor new vaccines; and improving monitoring of HSS programmes will require close collaboration between country Ministers of Health and Alliance partners and especially WHO and UNICEF field presence.

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

- 9.1 No change currently planned for 2012.

10. Risk implications and mitigations

- 10.1 A significant risk for GAVI is that vaccines could be wasted if they are not managed properly. The risk is higher in countries that are introducing new vaccines and that have DTP3 coverage less than 70% (following the December 2010 Board decision to reduce the DTP3 filter to 50 % as a once only initiative) because their immunisation and health systems are weak. Close monitoring and remedial action where required is intended to mitigate this risk, however increased scrutiny will also place additional demands on government staff. The potential sensitivities with government partners may increase if Alliance partners recommend delaying or varying the pace of new vaccine introduction. Regular communication across partners and with Government is required to promote country leadership and to minimise information gaps and misunderstanding.

11. Legal or governance implications

- 11.1 This report is for information only and there are no legal or governance implications.

12. Consultation

- 12.1 The paper was shared with WHO and UNICEF at HQ level prior to distribution to the Board.

13. Gender implications / issues

- 13.1 Since the last Country Programme update, and following the Monitoring IRC's recommendation to develop a more sensitive instrument to measure gender-related barriers and gender equity issues, the Secretariat has strengthened the questions on gender in the Annual Progress Report form.

14. Implications for the Secretariat

- 14.1 The Secretariat is slowly strengthening its stewardship of GAVI resources in eligible countries through increased support in the Country Programme team and TAP. This will include intensified action to identify and resolve problems by facilitating or coordinating responses with Government partners and across the GAVI Alliance. Although the Board agreed in November 2011 to allocate additional resources in the 2012 Budget and recruitment is underway, additional country responsible staff within the Secretariat will not be in place until the second half of 2012. The AVI team from Policy & Performance Department will move to the Country Programmes Department once a new MD for Country Programmes is in place. With the shift, the team will expand its focus from introduction to introduction and implementation.
- 14.2 The terms of the legal relationship between GAVI and Countries for vaccine and cash support is scattered through a number of documents including the Country Application Guidelines, Country Proposals and Decision Letters. The GAVI Secretariat has been working to simplify and clarify this relationship and to put all the terms into one document and in this process has consulted with a number of present and past Developing Country Board members. The Secretariat has taken the comments provided by the Board members into consideration in finalising the new Partnership Framework Agreement (Grant Agreement). A draft of this Agreement has also been shared for information with Alliance Partners, WHO, UNICEF and PAHO. The new Agreement will be rolled out to Countries on a staggered basis and lessons learnt will be incorporated subsequently.

Attachment 1

Summary outcome of February 2012 IRC (NVS and HSFP) and May HSFP IRC

1. New Vaccine Support

Country		Type of support		
		Penta	PCV	Rota
1	Afghanistan		Conditional	
2	Bangladesh		Approval	
3	CAR			Approval
4	Guinea-Bissau		Approval	Approval
5	Haiti		Clarifications	Clarifications
6	Indonesia	Clarifications		
7	Kenya			Conditional
8	Lao PDR		Approval	
9	Lesotho		Clarifications	
10	Liberia		Conditional	
11	Mauritania		Approval	
12	Myanmar (new application)	Approval		
13	Nigeria		Approval Phase 1 Conditional Phase 2 & 3	
14	PNG		Approval	
15	Sierra Leone			Approval
16	Togo		Approval	Approval
17	Zambia			Approval
18	Zimbabwe			Approval

2. Health System Strengthening support under HSFP (February 2012 IRC)

Country	Application Channel	Outcome
Laos PDR	Common Proposal Form	Approval with Clarifications
Solomon Islands	Common Proposal Form	Approval with Clarifications
Liberia	Common Proposal Form	Approval with Clarifications
United Republic of Tanzania	Common Proposal Form	Further information required
Afghanistan	Common Proposal Form	Resubmission
Ethiopia	Funding Request Template	Approval with Clarifications
Malawi	Funding Request Template	Further information required

3. Health System Strengthening Support under HSFP (May 2012 IRC)

HSS Proposals

Country	Application Channel	Outcome
Afghanistan	Common Proposal Form	Approval with Level II Clarifications
Burkina Faso	Common Proposal Form	Resubmission
Burundi	Common Proposal Form	Approval with Level II Clarifications
Comoros	Common Proposal Form	Approval with Level II Clarifications
Malawi	Funding Request Template	Resubmission
Rwanda	Common Proposal Form	Resubmission
Sierra Leone	Common Proposal Form	Approval with Level II Clarifications
United Republic of Tanzania	Common Proposal Form	Approval with Level II Clarifications
Zimbabwe	Common Proposal Form	Resubmission

HSS Monitoring (early submission of APRs in order to allow reprogramming)

Country	Application Channel	Outcome
Nepal	Joint Annual Review	Fund release Approved
Guinea Bissau	APR	Insufficient Information
Burundi	APR	Approval with Level II Clarifications

CSO Type B Extension

Country	Application Channel	Outcome
DRC	CSO Type B Extension	Approval with Level II Clarifications

Attachment 2

Terms of Reference:

Technical Advisory Group on Health System Strengthening (TAG-HSS)

The purpose of the TAG-HSS is to provide advice and support the GAVI Alliance CEO in achieving the Alliance's Strategic Goal 2, which aims at strengthening the capacity of integrated health systems to deliver immunisation in countries.

Background

In 2010 the GAVI Board decided to bring together the GAVI's cash based health systems support into one support window under a Health Systems Funding Platform (HSFP)¹ which envisioned close collaboration and partnership with the Global Fund for AIDs, TB and Malaria and the World Bank, with facilitation from the WHO.

For GAVI, adoption of the platform approach allowed consolidation of multiple streams and entailed transitioning from the current HSS, ISS and CSO support windows into the 'Platform'. Throughout 2010 and 2011, GAVI put a lot of effort into operationalizing the HSFP in collaboration with the Global Fund, the World Bank, and WHO.

In July 2011 the GAVI Board made the HSFP window available to all countries so that they could submit joint applications using one application form to GAVI and Global Fund. In November 2011 the GAVI Board approved the Performance Based Financing (PBF) instrument for its cash-based support to countries to be rolled out in 2012.

The Board requested the Secretariat to create an advisory group that would engage partners and technical experts.

Commencing in January 2012 GAVI is accepting HSFP applications on a rolling basis. Applications received in the first quarter of 2012 will be reviewed by IRC in May 2012.

GAVI is concurrently also developing a policy on country-tailored engagement. The policy will enable the Alliance to adopt more country context specific approaches based on implementation and institutional capacities of the countries, specific bottlenecks for the performance of immunisation programmes, etc. This will require that health system strengthening support and funding modalities also be tailored to the country context.

The success of the consolidated health system strengthening support will be measured against Strategic Goal 2 of the GAVI Alliance Strategy 2011-2015, and its goal level indicators and strategic objectives.

Currently there are a number of inter-agency processes with the aim to improve coordination around HSS and implementation of the health system funding platform. There is a need to consolidate this work while at the same time ensuring a better representation of country level stakeholders.

¹ The core principles of HSFP are: (a) harmonization of the development partner assistance; (b) country ownership and alignment of development partners with one comprehensive national health strategy/plan; (c) using a common monitoring and evaluation framework; (d) using common fiduciary safeguards mechanisms; and (e) using the country systems of financial management and procurement.

Engagement with a diverse range of partners with proven expertise and competencies in health system strengthening is necessary for GAVI to be successful in its mission and will also allow the GAVI alliance to contribute to the work of others.

Objectives

The work of the TAG-HSS in advising the GAVI Alliance CEO in making its health system strengthening programmes more effective in countries will be guided by the following objectives:

- Increased effectiveness of health system analysis of and funding to address bottlenecks linked to immunisation outcomes in countries;
- Contribute to improved coordination of activities among national and international partners in the area of health system strengthening both at the global and country levels;
- Improved knowledge sharing and exchange of experiences among national and international partners and countries;
- Increased participation of civil society in health system strengthening dialogue and country level activities.

Scope of work and specific tasks

The TAG-HSS will advise the GAVI Alliance CEO on the design of effective, sustainable approaches and funding instruments for health system support. More specifically TAG-HSS will:

1. advance the analysis of health system bottlenecks hindering performance of immunisation programmes in countries, and identify effective operational approaches to address them;
2. facilitate dialogue with countries in order to better understand what works well and what needs improvement with regard to health system strengthening to deliver immunisation, and ensure that country feedback is reflected in the programme design and operations;
3. provide guidance on how to further develop result-focused health system strengthening through the Performance Based Financing (BPF) instrument as part of the health system funding platform (HSFP);
4. identify policy mechanisms to ensure long term sustainability of HSS investments in the framework of the national health system development plan in the context to the GAVI Alliance's core business;
5. lead to more effective engagement with the development partners and multilateral organisations at the global, regional and country level with the aim to improve quality, relevance and timeliness of technical assistance to countries; streamline operational procedures and tools, e.g. IRC processes, country application materials, on-going monitoring of grant implementation, etc.
6. provide guidance on more effective communication (externally and internally) by GAVI about its work in health system strengthening to deliver immunisation.

The TAG-HSS will also provide input in developing annual business-plan and deliverables for the Secretariat and its business-plan partners under the Strategic Goal 2.

While serving in advisory role to the GAVI Alliance CEO, TAG-HSS may also promote cross-organizational/Alliance learning and knowledge sharing. The work carried out by TAG-HSS and the Alliance in the area of health system strengthening may catalyze new initiatives and processes among other partners.

Working arrangements

The TAG-HSS is chaired by an external senior level health system expert appointed by the GAVI CEO. TAG-HSS is advisory in its role and it is not a governance entity. The TAG-HSS members will not be tasked with participation in the process of preparing PPC, Evaluation Committee, Executive Committee or Board papers.

The task team will include 13-15 members/experts.

The task team will meet twice per year for face to face meetings and quarterly through video/telecom meetings.

There may be temporary, time limited task teams created to work on specific topics and deliverables as needs emerge.

There will be a core group composed of the GAVI Secretariat and the GAVI Alliance institutional partners: WHO, UNICEF Programme Division, World Bank and the Bill and Melinda Gates Foundation. They will convene through video conference on a monthly basis for more regular coordination of work.

Time Frame and Activities

TAG-HSS will commence its work in June 2012. The following list is a high-level overview of some major tasks and milestones. A more detailed draft work plan will be developed prior the first face-to-face meeting of the TAG-HSS:

- TC/VC meeting with TAG-HSS members to discuss ToR (June 2012)
- First face-to-face meeting of TAG-HSS (September 2012)
- Quarterly teleconferences of TAG-HSS members

Some specific tasks

- Review of country case-studies on health system bottlenecks in underperforming countries
- Developing GAVI Alliance strategy for health system strengthening (November 2012).
- Providing advice to the secretariat on;
 - o Revision of HSFP application forms (July 2012);
 - o Development of operational guidelines for Performance Based Financing (July 2012);
 - o Updating application guidelines (August 2012); and
 - o Updating HSFP application guidelines (September 2012).

The above list is tentative and will be subject to revision at the first TAG-HSS face-to-face meeting.