The Global Fund Strategic Approach

to Health Systems Strengthening

Report from WHO to The Global Fund Secretariat

September 2007

TABLE OF CONTENTS

Global Fund Strategic Approach to Health Systems Strengthening

Report from WHO to The Global Fund Secretariat

1 Background

Discussion on the role of the Global Fund in funding health system strengthening (HSS) has a long history. Its Framework Document states it will support programmes that address the three diseases in ways that strengthen health systems. In April 2007, the Fifteenth Board meeting reaffirmed that the Fund's strategic approach to health system strengthening consists of 'investing in activities to help health systems overcome constraints to the achievement of improved outcomes in reducing the burden of HIV/AIDS, TB and malaria' (ATM). The question is therefore not ***whether*** the Global Fund invests in strengthening health systems, but ***how***. The Global Fund Board, at its Fifteenth Meeting, asked the Policy and Strategy Committee to make recommendations on four questions: the possible use and nature of parameters, of conditions and of ceilings for HSS funding, and how HSS funds might be applied for - exclusively within disease components or, in addition, through a separate HSS window.

The Board asked WHO to identify or convene a forum to provide input on health system strengthening as related to the Global Fund and other partners before the Sixteenth Board Meeting. This short paper draws on a range of knowledge and experience, especially the ***July consultation*** convened by WHO. This consultation discussed the wider context within which the Global Fund investments are made, and different options for each of the four questions. It was attended by health policy makers, managers and NGO representatives from 18 Global Fund recipient countries together with representatives from international NGOs and foundations; bilateral agencies; global health partnerships including the GAVI Alliance; and multilateral institutions including UNAIDS Secretariat, UNICEF and the World Bank (55 people in total, Annex 1).

As a major health financier, and with plans to increase its funding base, The Global Fund influences health systems both directly through the resources it provides, and more indirectly because countries sometimes adjust their policies and practices in response to the Global Fund approach to HSS funding, for example policies in such areas as workforce size, the roles of health workers, cost recovery, or the role of the private sector. Moreover, it gives signals to others through its investment decisions. The Global Fund has an evolving business model, and new strategic initiatives such as the rolling continuation channel and 'national strategy applications' (an approach to further enable 'programmatic funding')'[1] also need to be taken into account in the HSS debate. This paper however focuses on the wider HSS context, and the four Board questions. It will be used by the Global Fund Secretariat and the Policy and Strategy Committee to inform their own documentation and guidance for discussions on financing of Global Fund health system strengthening activities in preparation for the Sixteenth Board meeting.

[1] See Decision Point GF/B15/DP7 : Modified Application Process for Supporting Country Programs.

2 The wider context

There is ***renewed international interest*** in health systems. There is increasing realization that, while global health initiatives focused on specific health outcomes have helped catalyse attention and action on major health problems in recent years, without more effective health systems it will not be possible to reach and sustain agreed health goals.

There is ***growing clarity*** on the health systems agenda. The World Bank and WHO are working together on a framework for health system strengthening that can inform more coherent operational support to countries.

Box 1: The six building blocks of a health system

- Good ***health services*** are those which deliver effective, safe, good quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
- A well-performing ***health workforce*** is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. I.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive.
- A well-functioning ***health information system*** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants; health system performance and health status.
- A well-functioning health system ensures equitable access to essential ***medical products and technologies*** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good ***health financing*** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
- ***Leadership and governance*** involves ensuring strategic policy frameworks exist and are combined with effective oversight; coalition-building; regulation; attention to system-design, and accountability.

There is support for moving away from the stale vertical versus horizontal debate to a more ***'diagonal'*** approach. It aims to alleviate problems which can be created by vertical programmes while recognising a continued need for specialization of some functions. A key message is that programmes are part of any health system, and it is impossible to scale up services to any significant extent without a stronger system. At the same time, the rationale for strengthening health systems is to better deliver quality health programmes and services. This shift is beginning to lead to more interaction between programme and systems staff in countries and in international agencies. Linked to this is the renewed call for ***'integration'*** of health service delivery, which is concerned with ensuring a continuum of preventive and curative services at the point of delivery, based on an agreed set of interventions[2].

[2] Integration refers to the links between different types of service; links between the community and the formal health system; links between the public, private and voluntary sector and links between levels of the health system - from outreach, through clinics to hospitals.

Box 2: A 'diagonal' approach to health system strengthening

- Taking the desired health outcomes as the starting point for identifying health systems constraints that 'stops' effective scaling up of services
- Addressing health systems bottlenecks in such a way that specific health outcomes are met while system-wide effects are achieved and other programmes also benefit
- Addressing primarily health systems policy and capacity issues
- Encouraging the development of national health sector strategies and plans, and reducing investment in isolated plans for specific aspects of health systems
- Robust monitoring and evaluation frameworks

Global aid architecture is in flux. The Global Fund, along with other international agencies, has endorsed the Paris Principles of harmonization and alignment with national health policies and systems, country ownership and accountability. These aim to reduce duplication and transaction costs experienced by countries. If taken to their logical conclusion, they will have a profound influence on how The Global Fund supports health system strengthening. There are also several emerging international health system strengthening initiatives - for example, from the UK, Norway and the joint 'Harmonization for Health in Africa' work by the World Bank, WHO, UNICEF, the African Development Bank and UNFPA. There are also relatively small but influential new sources of funds such as the GAVI Alliance 'health system strengthening' window. Leaders from eight international health organizations[3] agreed in July to engage with these ***in a coordinated manner***, to ensure effective support to countries. Standards and processes for national health strategies and plans are being developed. All these developments make it an important time for the Global Fund to be clarifying its approach.

Countries eligible for Global Fund grants ***are diverse***. An increasing number have robust national health sector strategies, medium-term expenditure frameworks, or health workforce development plans, but others do not. Some have relatively strong institutions, while others are still fragile. In some the Global Fund contributes a major share of the health budget; in others it is a much smaller player. The question is how to ensure the Global Fund's investment approach to HSS adequately reflects this diversity; does so in ways that reduces uncertainty and is based on clear criteria; has benefits for other health priorities - or at least does them no harm, and stays true to its business model of being country led, multi-stakeholder-driven innovative and results focused.

Irrespective of how the Global Fund eventually decides to fund health system strengthening, there are some critical pre-requisites that can create ***an enabling environment*** for building more effective health systems that the Global Fund should support along with other players

- better communication: of available evidence; of Global Fund policies and processes
- more and better technical assistance (TA) in different aspects of health systems - including greater regional and national TA capability
- political will at country level
- appropriate and agreed indicators to track progress in health system performance

[3] Gates Foundation; Global Fund; GAVI; World Bank; WHO; UNAIDS; UNFPA; UNICEF

These are discussed in more depth in section 7. The **four questions** posed by the Board can be looked at from two points of view: funder and applicant. During consultation it became increasingly evident that the questions on parameters, conditions and ceilings are inter-linked.

3 Parameters for 'allowable HSS activities'

Purpose and options

Explicit parameters for 'allowable HSS activities' are one way of giving greater clarity to what can be funded by the Global Fund. Some parameters already exist:

- Activities must clearly contribute to "help health systems overcome constraints to the achievement of [ATM] outcomes".
- Activities that are catalytic in nature are allowable.
- Major infrastructure investment is excluded.

The lack of more specific guidance has caused some difficulties for countries when preparing proposals and some Board constituencies have had concerns over 'mandate creep'.

Additional parameters can be set in different ways. For example,

- As a set of health system thematic or focus areas that reflect the biggest constraints-to improving ATM outcomes e.g. health workforce development; procurement and supply management systems
- Based on a particular level of the system e.g. facility or district level
- By defining excluded activities more explicitly
- Based on the scope or scale of a proposed activity

Experience with different options, their pros and cons

There are consistent messages on the biggest health system constraints to improved HIV/AIDS, TB and malaria outputs and outcomes, from different sources: from countries' analyses, from The Global Fund's analyses of problems with grant implementation, and from an increasing number of international reviews of health system constraints to achieving the different health MDGs:

- health workforce
- drug and other commodities procurement and distribution systems
- diagnostic services
- access - especially financial access
- management and coordination
- reporting and monitoring

Experience suggests that while certain constraints are common, it is risky to define focus areas too rigidly, because priorities differ across countries.

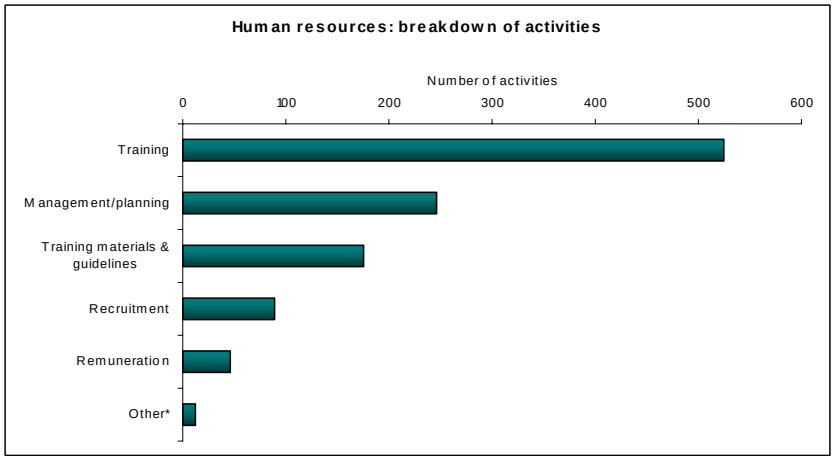
Box 1 Top health system bottlenecks to improved ATM outcomes in six countries

Biggest bottlenecks	Vietnam	Laos	Thailand	Indonesia	Nepal	Philippines
1	Surveillance, M&E system	M&E system	Governance	HRH	Coordination	Coordination
2	Collaboration	Coordination	Coordination	Policy & planning	HRH	Information system
3	HRH	Local planning	HRH	Information system	Surveillance system	HRH

Source: Identified by participants in Round 7 AAAH workshop, Thailand

The main categories of health system related activities supported by the Global Fund reflect the major groups of constraints. However, a review of the ***nature of activities*** within these categories is informative. For example, the chart in box 2 comes from a review of 98 approved proposals in 21 countries. Within the 'human resources and training' category, the great majority of activities were training related. Few proposals had recruitment or remuneration related activities. In terms of target groups for training, analysis showed that over 80% were directed at clinical training for health care workers and community health workers and 14% at training in procurement and supply management.

Box 2: Human resources: the nature of activities supported by the Global Fund



Source: Review of 98 approved proposals by WHO, 2006

The key problem seems to be less the lack of more specific parameters and more that many proposals still contain actions that are vague, and proposed in isolation from the wider health system. This makes it difficult to judge the extent to which the mix of activities proposed constitute or are part of a **balanced package of interventions** that fit with national policy and strategy in the country concerned. It also makes it hard to judge the extent to which proposed activities are likely to contribute to sustained improvements across services and outcomes.

A strength of the Global Fund's business model is that it is prepared to fund technically sound and well-justified proposals. This has allowed some countries to secure funds for a critical constraint to scaling up ATM outputs, where the solutions lie outside a programme's direct responsibility - Afghanistan, Malawi and Rwanda are good examples (e.g. the Afghanistan Round 2 integrated grant aimed to build

the capability of the Ministry of Public Health for the control of communicable diseases by supporting managerial and administrative capacity building and infrastructure development necessary for developing and supporting disease-specific programmes).

Box 3 New GAVI HSS window takes a mixed and flexible approach.

The GAVI HSS window uses the same basic parameter for allowable HSS activities as the Global Fund - it will fund actions that address health system bottlenecks to increased and sustained high immunization coverage. However, in addition, it indicates three priority areas in its guidelines, based on common constraints (health workforce mobilization, distribution and motivation; supply, distribution and maintenance systems for primary health care; organization and management of health services at district level and below). It stresses these are **not exclusive**, and other areas can be funded as long as the link to improved immunization coverage is made. Experience is positive so far, but the HSS window is still very new. So far, 16 out of 31 HSS proposals submitted have been approved.

An alternative to defining parameters more tightly is to provide examples of allowable activities. This too has its pros and cons. Examples can clarify what is allowable, but at the same time increase the risk of 'copy cat' proposals, and may limit innovation - which is a key aim of the Global Fund.

Main messages from the WHO consultation process

- The parameters for allowable HSS activities should **remain broad**. The most important parameter is activities that improve ATM outcomes, as identified above. Otherwise there is a strong view that there should be few prescriptions. Flexibility is key because of country diversity, and because it helps encourage innovation.
- However, some greater clarity on **exclusions** might be useful.
- There are **implications** for partners of a broad parameters approach:
  - Better guidance is needed…but no blueprints.
  - Co-operation / coordination among partners is very important, to ensure most effective use of all available funds
  - Funding for TA for proposal development and implementation is essential
  - Partners need to strengthen capacity to deliver relevant TA for health system strengthening - both for proposal development and implementation

"the Global Fund should retain the principle of 'give us a good plan and a good justification and we'll fund it' "
— quote from participant at the July consultation

4 The possible use and nature of conditionality for applying for HSS funding

Purpose and options
Conditions can be used for different purposes. They can provide guidance to help promote investment, to create an incentive for important pre-requisites for successful HSS funding (e.g. incentive to have a good national health plan), or they can be used to restrict entry and control access to funds. They are closely

related to parameters - indeed some use the terms inter-changeably. Conditions can be loose (such as demonstrating a link to ATM outputs and outcomes) or rigid (no national strategy, no funds). They may be designed to encourage certain processes or products deemed desirable - for example the pursuit of greater equity in service delivery; the participation of relevant stakeholders; essential interventions to be included. Conditions could be designed to reinforce features of the Global Fund's business model: for example, to catalyse change. Conditions may take different forms - guidance or fixed rules.

Experience with different options, their pros and cons

Experience suggests that conditions in the conventional sense don't work. There has been a move away from standard conditions set by a financing institution and applied to all countries, towards agreements negotiated with recipients on an individual basis. The language is changing. In the consultations there was much more support for the notion of a set of pre-requisites or principles. GAVI's 'principles' are a form of conditionality, to encourage good practice in proposal development. The need for mutual accountability rather than one-way conditions was also raised.

All conditions, even supposedly positive ones, have their pros and cons. For example, well intended but inflexible conditions such as 'no strategic plan, no funding', or matching funds, might penalise weaker, poorer health systems. However, linking a grant to initiation of the development of a country health workforce strategy could be positive. Complex conditions would have high transaction costs for all concerned. Conditions on process can be useful, but can also be labour intensive as they take a special effort on the part of countries and proposal review teams to make them work in practice.

Box 4 Can conditions support effective health system strengthening? thoughts from Kenya TB programme

Yes, if this encourages HSS proposals to

- Link with overall health sector development policy and strategies
- Focus on delivering an essential package of care that includes ATM, through both public and private providers
- Focus on lower levels of the health system

Yes, if the proposal development process leads to

- A critical assessment of health system constraints, and needs
- A critical evaluation of a country's political commitment
- The promotion of programme ownership by stakeholders, including those outside the health sector

The fact that the Global Fund is planning to substantially increase in size, and that other global financing institutions are changing, makes the discussion of conditions important.

Main messages

- The fewer conditions the better, but countries need to know what is expected. Guidance is needed and wanted.

- One size cannot fit all. Flexibility is essential.
- Any conditions should be simple, clearly communicated and have transaction costs proportionate to their benefits.
- Proposals should be more clearly aligned with (i.e. show how they contribute to) national health development plans, medium term expenditure frameworks (MTEFs) and Poverty Reduction Strategy Papers (PRSPs).
- Conditions should apply to private sector and civil society organizations as well as public sector institutions.
- The Global Fund is a partnership. Mutual accountability is important.
- There are some pre-conditions that seem widely acceptable, shown in box 5

Box 5: Acceptable pre-conditions

- Proposals should be based on a sound analysis of HSS constraints to improved ATM outputs and outcomes.
- Proposals should be linked to ATM service outputs and outcomes, (and possibly MDG targets)
- Proposals should provide evidence of commitment to and alignment with the health sector plan or strategy. Guidance on how to ensure consistency with national plans would be useful, providing they are simple and clear
- Proposed HSS actions should be based on best available evidence of what works and what does not.
- Proposals should provide evidence of involvement of relevant stakeholders beyond a programme and possibly beyond the health sector, in both proposal development and implementation oversight

While many of these suggested 'conditions' are not new to the Global Fund, they have been strongly and frequently recommended during the consultation process. Like the parameters discussion, they have implications for support from partners; for countries and for Global Fund structures, guidelines and procedures.

5 The possible use and nature of ceilings for HSS funding

Purpose and options

Financial ceilings would set a limit on the Global Fund's investments in HSS. Behind this question is a concern about responsible risk management. Ceilings could help keep a focus on the Global Fund's mandate and manage the 'bottomless pit' concern often voiced in discussions on health systems investment. They could reinforce the point that the Global Fund is only one of many financiers in HSS. Currently, the GFATM does not have ceilings for disease specific applications, and they are only being considered if there is a separate HSS window.

Financial ceilings can be set in different ways: as a **global** 'pot' of funds (setting aside a fixed sum over a certain time frame) and / or on a **country specific** basis. Global ceilings address the 'bottomless pit' concern, but raise questions about how to manage applications for funds. Country ceilings could be set using a formula (for

example, population, income or need), but this would need to be very simple to be workable, and to be seen as fair across different types of countries. Country ceilings might help encourage a broad spread of activities and country coverage, as they provide a measure of predictability. Ceilings could be set in **absolute** terms or as a **percentage** - of a specific grant, or of overall funding. Alternatively there could be no ceiling, with the maximum determined by the quality of the proposal alone. The nature of the activity to be funded is another way to think about ceilings: the cost of relaxing specific health system constraints may be relatively modest and is quite different from embarking on financing the health system as a whole. Any policy on ceilings would need to be reviewed after a period. Finally, there is the option of having a **'floor'** rather than a ceiling, as one way for the Global Fund to encourage actions on major health system constraints.

Experience with ceilings, and their pro's and cons

Ceilings serve to reassure cautious investors, and can be part of a 'learning by doing' approach. However, ceilings are difficult to manage well. Ceilings do not easily reflect other considerations such as country absorption capacity or funding from other donors. There are other ways to achieve at least some of their aims. For example, by taking account of national plans and other donor investments in a country, when assessing financial support.

Box 6: The GAVI HSS window and its experience with ceilings

In its decision in December 2005, the GAVI Board approved an initial global ceiling of USD500 million for 2006 - 2010, with an evaluation in 2010 and an overall time horizon of 2015. It also approved that country specific budget envelopes would be determined by a formula based on GNI per capita and the number of newborns per year. There are some concerns about the value and fairness of this formula for very small and very large population countries. USD266 million out of USD500 million have been approved by the Independent Review Committee for 16 of the 29 countries that have applied so far. Approximately 40 more have indicated they are likely to apply in the next round later this year. The Board will discuss forecasted funding requirements for this GAVI HSS window at its next meeting.

There are some differences between GAVI and the Global Fund when considering options for ceilings. The Global Fund's mandate for three diseases makes country specific formulae harder to set in ways that make sense and would be fair. The Global Fund already has an established track record in financing HSS activities[4] where the case is thought well-argued. Moreover, its experience is that national CCMs behave responsibly and are generally unlikely to let through unreasonably large HSS proposals.

Does HSS really run the risk of being a 'bottomless pit' of expenditure?. More work is needed - signalled in section 7. However, experience suggests that with the possible exception of infrastructure, many of the interventions needed to address specific ***system constraints*** (as opposed to financing the system as a whole) are relatively inexpensive. For example, improved coordination, planning and management capacity, supervision, or improved equipment maintenance systems are not generally high cost activities. What may be more important than money is support to create momentum for action. Here the Global Fund can help leverage

[4] See table 6 in July consultation background paper 3

significant change with rather small investment. To give one example, in Ethiopia large Global Fund grants for drugs and commodities overwhelmed the national pharmaceutical supply service (PASS). This was used by the MOH as an opportunity to accelerate improved procedures in PASS, with only a small amount of funds needed for great effect.

The bottom line is that ceilings provide certainty for the Global Fund, but may constrain applicants. And ceilings could risk sending a conflicting message about The Global Fund, for whom a key objective is significant scale-up of ATM programmes.

Main messages

- Avoid ceilings. Where the concern is about salary costs, it is better to say this upfront and negotiate country specific strategies.
- The use of an 'HSS floor', possibly as a percentage of any grant, might be more useful to help promote the desired 'diagonal' approach, but needs further exploration

6 Pulling it together: modalities for supporting HSS

Purpose
The first three questions addressed here - on parameters, conditions and ceilings - are all part of the same debate over ***Global Fund policy***: how to improve the Global Fund's support for HSS in diverse countries while responsibly managing risks for both the Global Fund itself and countries. The fourth question has more to do with internal ***Global Fund procedures***: whether or not to have a separate window for HSS (in addition to funding HSS within disease-specific components).

Options and experience
There are good and bad experiences in preparing successful proposals with and without a separate window. The TRP's experience with low quality stand alone HSS applications - whether it is called a cross-cutting, integrated or HSS component, is well-documented. Round 6 experience, in which health system strategic actions were located within disease components is also important here: the TRP noted that the quality of proposed HSS strategic actions was no higher in round 6 than in round 5. It seems other factors affect proposal quality.

The main ***argument*** deployed for keeping HSS within a disease component is that programmes are part of systems and it is artificial to separate the two. The ***practical problem*** with having HSS within a disease component application is to do with the process by which proposals are developed. If the process continues to be seen as largely the province of an individual programme and its more disease-focused partners, then few will address health system constraints in a truly systemic way, and the risk of unintended, unwanted repercussions on other programmes and services will be greater. It is not easy to do this differently but it is possible even within current Global Fund arrangements, as was illustrated by the Kenya TB programme in the July consultation. Another argument in favour of

integrating HSS activities within disease components is that it makes the proposal development process simpler, meaning less work for countries, while still remaining sufficiently flexible.

The main ***arguments*** deployed for having a separate HSS component are that there are more opportunities for 'integration'; that it is the only way to initiate truly system-wide action; that it is an additional way of signalling the Global Fund's support for HSS, and might make it easier to mobilise HSS technical support. The main ***practical problems*** with having a separate HSS component are to do with judging what goes into that component versus a disease component, and the creation of yet another application channel. Indeed, an interesting suggestion was made in the July consultation that it might be helpful to reduce the number of application channels from three to one, rather than increase them from three to four. This was not discussed in any detail, but merits consideration.

Main messages

- The Global Fund should support programme based approaches where possible.
- Where Global Fund specific proposals are needed, **opinion remains divided** on whether countries should be asked to apply for HSS funds through disease specific components only, or in addition through a separate HSS component. The idea of reintroduction of a 'cross-cutting' component has some traction. It may be especially important for fragile states with very weak health systems, and for activities that don't fit well within disease programmes.
- What seems more important to enhance the Global Fund's role in HSS than the question of what sort of application window is the question of **technical support**. More and better support is needed in proposal development to bring together ATM and HSS perspectives and key national players, and afterwards during implementation.
- Whatever modality of support is decided upon by the Board, good **indicators** for tracking changes in health system performance are needed.

7 Summary and implications for different stakeholders

The discussion on parameters, conditions and ceilings is all really part of the same debate: how can the Global Fund best invest in HSS in order to improve ATM outcomes? Underpinning the discussions has been a recognition of country **diversity**; a need to retain the Global Fund's emphasis on **innovation** and on results. There was support for the principle of **'integration'** of service delivery where possible that allows delivery of ATM services as part of an essential package of care - and for developing a more '**diagonal approach**' to HSS that brings programme and systems experts together.

The main messages around the **four questions** can be summed up as follows

- Retain flexibility. Keep the parameters for ‘allowable HSS activities’ as broad as possible (perhaps only indicating major exclusions); keep conditions as loose as possible; avoid ceilings. There is a set of pre-conditions to build on that are widely acceptable. They are not new to the Global Fund but would benefit from more clarity, visibility and support.

- Guidance is needed and wanted both on the Global Fund rules and conditions, and on how to assess and address health system constraints, to reduce uncertainty. This should be clear and simple.
- The question of an HSS window is a procedural not a policy question. Opinion remains divided. The window question becomes less important if key aspects of the enabling environment are addressed: better access to information; access to the right sort of technical assistance, and procedures that further encourage a 'diagonal approach'.
- Consideration should be given to the possible implications of any decisions for Global Fund architecture, processes and capacity at global and country level. For example, the structure of the TRP; guidance to CCMs, indicators for monitoring performance.
- Irrespective of the Board's decision on any of the specific questions, fostering an **enabling environment** is key to improving the Global Fund's role in HSS

Main messages about the **enabling environment:** implications for countries, the Global Fund, and other partners.

1. Better access to information
   This was a recurring theme. Two sorts of information are required. Information on the Global Fund's own rules and procedures. Second, access to best available evidence on effective HSS interventions, on costs and on experience with good strategy design.

   A clear message was that information on the Global Fund's website is useful but not sufficient. The July consultation was a very valuable communication exercise in its own right. Other opportunities to allow stakeholders to discuss issues in a technical and supportive way need to be encouraged.

   Technical agencies need to help improve access to evidence. Knowledge is increasing but it could be made more readily accessible.

2. Better technical assistance for health system strengthening
   More and better TA is needed, especially if the parameters for 'allowable HSS activities' remain broad. Proposals are only a beginning, and good proposals do not automatically translate into better services. Funding for TA for proposal development and also for implementation is essential. There is a need to move beyond ad hoc individual, 'project' specific consultancies identified at short notice to a more strategic approach in which appropriate TA is available; reflects local needs, and is used. Other organizations such as GAVI are also struggling with this and there is room for more coordinated approaches. Regional and national TA capabilities need to be strengthened.

3. More coordination and co-operation at country level
   The Global Fund is too big a player to operate on its own. Broad parameters and loose conditions means co-operation and coordination among partners is very important, to ensure most effective use of all available funds. There is also a need to enable greater collaboration across systems and programme management authorities in countries.

4. The importance of political will at country level, to steer and sustain efforts when almost inevitable difficulties are encountered in implementation

5. Greater mutual accountability

6. Credible indicators for tracking health system performance.
   The Global Fund is already part of work led by WHO and the Health Metrics Network to develop a **health system metrics dashboard** for monitoring trends in health system performance - including trends in equity, which many information systems neglect to report on. This is being piloted in Tanzania. Additional suggestions made during the consultation will be shared with the group working on the dashboard.

Annex 1

World Health Organization

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Global Fund Strategic Approach to Health Systems Strengthening

DAY 1

0800 - 0900 Registration

0900 - 0930 Session 1
Welcome, background and purpose of the consultation

Background, scope and purpose: The fifteenth GFATM Board meeting decided that the Global Fund's strategic approach to health system strengthening is 'investing in activities to help health systems overcome constraints to the achievement of improved outcomes for HIV/AIDS, TB and malaria'. The question is therefore not whether the GF invests, but how. The GF Board identified four questions to be addressed. It also requested that WHO convene a forum to provide input on health system strengthening as related to the Global Fund and other partners, before the Sixteenth Board meeting.

This session will recap the GF mandate. It will set out the 4 questions, and clarify meeting objectives, process and products.

Overview of background and purpose of consultation
Hiro Nakatani, 5 minutes
Plenary discussion: clarifications only
Introduction of participants and handover to meeting Chair

0930 - 1030 Session 2 part 1
The health systems agenda: global developments and country perspectives

Background and scope: The aim of this session is to set the broader and evolving context within which the GFATM Board's specific questions are to be discussed. It will briefly review the accelerating international focus on strengthening health systems; emerging clarity on the health system strengthening agenda, funding needs, and on roles of different players; the current status of national sector strategies, medium term expenditure frameworks; and approaches to monitoring health system performance. Two country perspectives will reflect on how all this is being translated at country level.

Overview of global developments: *Anders Nordstrom, 15 minutes*
Two country perspectives: 5-7 minutes each
Caroline Kayonga; Aynura Ibraimova
Plenary discussion

1030 - 1100 BREAK

1100 - 1230 Session 2 part 2

Plenary discussion continued

1230 - 1330 LUNCH

1330 - 1500 Session 3 part 1

Parameters for defining priority areas for GF funding of health system strengthening activities

Background and scope: The aim of this session is to address the first of the four questions posed by the GFATM Board. Parameters for allowable HSS investments can be set in a number of different ways. The challenge is to frame GFATM parameters in ways that are sufficiently flexible to respond to different country needs, but also provide sufficient direction to reduce the confusion and uncertainty experienced by countries, the TRP and the Board. The session will review the biggest health system constraints faced by HIV, TB, and malaria. It will summarize GFATM experience across the seven rounds in defining parameters for investment to overcome these constraints, and how these have worked at country level. It will draw on GAVI experience with defining parameters for funding. Some options for defining parameters identified so far include: defining a set of 'thematic' or focus areas; focusing on a particular level of the system; defining non-allowable activities more clearly; having greater clarity on what it makes sense to fund on a programme specific basis, and what through other modalities. The session will consider these and other options, their pros and cons, and how they are likely to work in practice. Two country perspectives will be presented.

Introduction *Diana Weil, 10 minutes*
Two country perspectives: 5-7 minutes each
Piya Hanvoravongchai; Hudson Nkunika
GAVI experience: Craig Burgess, 10 minutes
Plenary discussion (part 1)

1500 - 1530 **BREAK**

1530 - 1700 **Session 3 part 2**
Continued discussion in plenary

1700 **Summary of day 1**
Review of progress; links to and challenges for day 2

1800 **COCKTAIL, WHO MAIN BUILDING RESTAURANT**

DAY 2

0830 - 0840 **Day 2 objectives and programme**

0840 - 1000 **Session 4**
The possible use and nature of conditionality

Background and scope: The aim of this session is to address the question posed by the Board on whether to attach conditions to any HSS funding. Here the term is used to mean pre-conditions or prerequisites for **application** for HSS funds - beyond those already in place. The session will consider the pros and cons of alternatives, from the perspectives of countries and the GFATM. Issues to consider include: a need to be clear what any conditions are for: are they to restrict entry? to provide guidance to applicants? to facilitate spending? Second, the GFATM as a major donor has an important role in signalling to others, and it also wants to avoid 'going backwards' in terms of its shift from project to programme support. Third, any conditions should be as simple as possible, as they will have implications for transaction costs for countries; for proposal development support; for TRP processes, and for other donors. Options so far identified fall into two broad categories: conditions to encourage greater **harmonization and alignment**, and - not unrelated - conditions on **proposal preparation process**. Examples that have been suggested include: proposals should show how intended actions fit with priorities in a national health sector framework; where a country lacks an accepted and costed national health sector strategy, health workforce development plan or costed programme plan, a condition of obtaining GFATM funds could be that it agrees to develop these. Matching funds is another possibility. Additional conditions on proposal preparation processes that

might help quality and prospects for implementation have been suggested: revised membership of the proposal preparation team and the CCM; some more inclusive consultation processes. In proposal review, many would argue that the spirit of any conditions must be understood and interpreted as guidance rather than rigid rules. Respondents will provide practical perspectives.

Introduction *Brenda Killen, 5 minutes*
Perspectives from two respondents 5 minutes each
Morris Edwards; Jeremiah Chakaya
Plenary discussion

1000 - 1030 BREAK

1030 - 1230 Session 5
The possible use and nature of ceilings for HSS funding

Background and scope: The aim of this session is to address the third question: whether limits should be set on the quantity of funds that could be requested for HSS activities. As before, this session will discuss different options, and implications from the perspectives of different stakeholders. There are a number of issues to consider. Currently, the GFATM does not have ceilings for disease specific applications. There are arguments for and against ceilings. Behind the Board's question is a concern about responsible risk management. In terms of options, the discussion on ceilings can be cast in different ways: for example, by the **nature of activity** to be funded and in terms of **financial limits**. Financial ceilings may be set as a **global ceiling** (setting aside a fixed sum over a certain time frame) and / or on a **country specific** basis. GAVI does both. Global ceilings address the 'bottomless pit' concern, but raise questions about how to manage applications for funds. Country ceilings can be set using a formula, which must be very simple to be workable. Financial ceilings can also be set in **absolute** terms or as a **percentage** of a specific grant. Another suggestion is that ceilings be determined by the quality of the proposal and past absorption capacity. Any ceilings could be reviewed after an agreed time. The question of having a **'floor' as well as a ceiling** to HSS proposals has also been raised, as one way for the Fund to encourage actions on major health system constraints. Respondents will provide practical perspectives.

Introduction *Brenda Killen, 5 minutes*
Two respondents, 5 minutes each
Wei Ran; Joy Phumaphi
Plenary

1230 - 1330 LUNCH

1330 - 1530 Session 6
Pulling things together - options for channelling GFATM investment, and implications for GF structures and procedures

Scope: The aim of this session is to address the fourth question asked by the Board, which concerns modalities for channelling GFATM funds for HSS. This session will take stock of discussion in previous sessions to inform the very practical question on options for channelling GFATM investments. A range of options exist, and the discussion will include but not be limited to the question of whether or not to have a separate HSS component. The implications of different alternatives, primarily from a country perspective but also implications for GFATM structures and processes, will be considered. The session will begin with three participants from different constituencies reflecting on discussions to date; and considering implications for GFATM funding modalities, and associated structures and procedures

Taking stock; looking forward: reflections (5 minutes each)
Asia Russell; Jimmy Kolker; David Mwakyusa
Plenary discussion
Half way summary of key messages emerging: *Maureen Law*

Plenary continued

1530 - 1600 **BREAK**

1600 - 1730 **Session 7**
Emerging recommendations and conclusions

Plenary, and summary by Chair

1730 - 1745 **Session 8**
Closure

Annex 2

Consultation on Global Fund Strategic Approach to Health Systems Strengthening
WHO, Geneva, 30 -31 July 2007
List of Participants

NAME & ADDRESS

Mahomed Fareed Abdullah
Director: Technical Support
International HIV/AIDS Alliance
Queensberry House
104 Queens Road
Brighton BN1 3XF
United Kingdom
fabdullah@aidsalliance.org

Eddie Addai
Director Policy Planning, Monitoring and Evaluation and Co-Chair of Strategic Partnership with Africa
Ministry of Health
P.O. Box M44
Accra
Ghana
eddieaddai@yahoo.co.uk

Anshu Banerjee
Senior Programme Officer
Country Support Team
GAVI Alliance Secretariat
c/o UNICEF
Palais des Nations
CH-1211 Geneva 10
Switzerland
abanerjee@gavialliance.org

Karlo Boras
Member of Developing Country NGO Delegation on Global Fund Board
JAZAS
27. marta 35
11000 Belgrade
Serbia
karlo.boras@jazas.org.yu

Martien Borgdorff
Executive Director
KNCV Tuberculosis Foundation
PO Box 146
Parkstraat 17 (Hofstaete Building)
2514 JD - The Hague
The Netherlands
borgdorffM@kncvtbc.nl

Craig Burgess
Senior Programme Officer
Health Systems Strengthening
GAVI Alliance Secretariat
c/o UNICEF, Palais des Nations
CH-1211 Geneva 10
Switzerland
cburgess@gavialliance.org

Jeremiah Chakaya
Technical Expert
National Leprosy and TB Programme
Ministry of Health
P.O. Box 30016
00202 - Nairobi
Kenya
chakaya@todays.co.ke

Morris Edwards
Deputy Programme Manager
Principal Recipient
CARICOM Secretariat
Turkeyen
Greater Georgetown
Guyana
medwards@caricom.org

Norbert Forster
Under Secretary: Health and Social Welfare Policy
Ministry of Health and Social Services
Private Bag 13198
Windhoek
Namibia
undersec@healthnet.org.na
nforster@mhss.gov.na

Eric A. Friedman
Senior Global Health Policy Advisor
Physicians for Human Rights
1156 15th Street, NW, Suite 1001
Washington, DC 20005
United States
efriedman@phrusa.org

Paulo Ivo Garrido
Minister of Health
Ministry of Health
Ave Eduardo Mondlane
N 1008 Maputo
Mozambique
pigarrido@misau.gov.mz

Peter Godfrey-Faussett
TRP Chair
London School of Hygiene and Tropical Medicine
Department of Infectious and Tropical Diseases
LSHTM, Keppel Street
London WC1E 7HT,
United Kingdom
Peter.Godfrey-Faussett@lshtm.ac.uk

Deepak Gupta
Additional Secretary
Ministry of Health
Government of India
Nirman Bhavan
New Delhi 110 011
India
dgupta51@rediffmail.com
asdg-mohfw@nic.in

Piya Hanvoravongchai
Coordinator
Asia-Pacific Action Alliance on Human Resources for Health
IHPP-Thailand
Ministry of Public Health
Sataranasuk 6 Road
Nonthaburi Province 11000
Thailand
coordinator@aaahrh.org

Lennarth Hjelmåker
Ambassador - HIV/AIDS Matters
Ministry of Foreign Affairs
SE-10339 Stockholm
Sweden
lennarth.hjelmaker@foreign.ministry.se

Cassia van der Hoof Holstein
Director, Rural Health
William J. Clinton Foundation HIV/AIDS Initiative
55 West 125th Street
New York, NY 10027
cassia@clintonfundation.org

Ainura Ibraimova
Deputy Minister of Health
General Director of the Mandatory Health Insurance Fund
122, Chui ar
Bishkek 720040
Kyrgyz Republic
a_ibraimova@foms.med.kg

Jantine Jacobi
Senior Adviser, Country Support for Treatment and Care
20 Avenue Appia,
CH-1211 Geneva
jacobij@unaids.org

Caroline Kayonga
Permanent Secretary
Ministry of Health
P.O. Box 84
Kigali
Rwanda
ckrwiva@yahoo.com

Ambassador Jimmy Kolker
Deputy U.S. Global AIDS Coordinator
Department of State
S/GAC SA-29, 2nd Floor
2201 C. Street NW
Washington, DC 20522-2922
United States
kolkerjj@state.gov

Gilbert Kombe
Senior HIV/AIDS Technical Advisor
4800 Montgomery Lane, Suite 600
Bethesda, MD 20148
United States
Gilbert_Kombe@abtassoc.com

Joep Lange
Professor of Medicine
Center for Poverty-related Communicable Diseases
Academic Medical Center
University of Amsterdam-T125
Meibergdreef 9
1105 AZ Amsterdam
The Netherlands
j.lange@amc.uva.nl

Maureen Law
Suite 4C
268 First Ave.
Ottawa ON K1S 2G8
Canada
mlaw@ca.inter.net

Gabriele Mallapaty
Senior Advisor
Health Systems Strengthening
UNICEF
Three United Nations Plaza
New York, New York 10017
USA
gmallapaty@unicef.org

Shaun Mellors
Senior Technical Advisor
Civil Society Development
International HIV/AIDS Alliance
Queensberry House
104-106 Queens Road
Brighton BN1 3XF
United Kingdom
smellors@aidsalliance.org

Vincent Musowe
Policy and Technical Advisor to Permanent Secretary
Ministry of Health
PO Box 30205
Lusaka
Zambie
Musowe@zamtel.zm
Musowevincent@yahoo.co.uk

Mr Simon Mphuka
Executive Director
Church Health Association of Zambia
Ben Bella Road
P.O Box 34511
Lusaka
Zambia
mphuka@zamnet.zm

David Mwakyusa
Minister for Health
Ministry of Health
P.O. Box 9803
Dar-es-salaam
Tanzania
dmwakyusa@moh.go.tz

Francoise Ndayishimiye
Secrétaire Exécutif Permanent du
Conseil National de lutte contre le SIDA
Board Member in the GFATM in the
Communities Delegation
Chausée Prince Louis Rwagasore,
Immeuble de la Banque de la ZEP
BP 816
Bujumbura
Burundi
francnd@yahoo.co.uk

Hudson Z. Nkunika
Health Systems Strengthening
Coordinator and HSS Desk Officer for
Global Fund
Ministry of Health Headquarters
P. O. Box 30377
Lilongwe 3
Malawi
mchukuchuku@yahoo.co.uk

Francis Omaswa
Executive Director
Global Health Workforce Alliance
(HWA)
World Health Organization
20, avenue Appia
Ch-1211
Geneva 27
omaswaf@who.int

Gorik Ooms
Executive Director
Médecins Sans Frontiéres Belgium
Rue Dupré 94
1090 Brussels
Belgium
gorik.ooms@brussels.msf.be

Joy Phumaphi
Vice President Human Development
The World Bank
1776 G Street NW
Washington, DC 20433
United States
jphumaphi@worldbank.org

Bob Pond
Health Metrics Network
World Health Organization
20, avenue Appia
CH-1211 Geneva
pondb@who.int

Carole Presern
Counsellor (Specialised Agencies/
Development)
United Kingdom Mission to the UN
37-39 Rue de Vermont
1211 Geneva 20
carole.presern@fco.gov.uk

Wei Ran
Senior Program Officer
Division of International Organizations
Department of International
Cooperation
Ministry of Health
P.R China 100044
weiran@chinaaids.cn

Asia Russell
Director International Relations, Health
Gap
4951 Catherine Street
Philadelphia, PA 19143
USA
asia@healthgap.org

Lars-H. Selwig
First Secretary
Development Policy
Permanent Mission of Germany
28c, chemin du Petit-Saconnex
CH-1209 Geneva
lars.selwig@diplo.de

Stephanie Simmonds
Member GFATM Technical Review
Panel (TRP)
Mejlijina 8, Stari Grad
71000 Sarajevo
Bosnia-Herzegovina
sarajevohospice@yahoo.com

Krista Thompson
Vice President
General Manager, Global Health
BD (Becton, Dickinson & Company)
Becton Drive
Franklin Lakes, NJ 07417
USA
krista_thompson@bd.com

Wim Van Damme
Professor in Public Health
Institute of Tropical Medicine
Nationalestraat 155
2000 Antwerp
Belgium
WVDamme@itg.be

Sayad Shukrullah Wahidi
Director-General Policy and Planning
Ministry of Public Health
Kabul, Afghanistan
c/o WHO, Kabul, Afghanistan
wahidi2uk@yahoo.com

Francisco Yepes
Executive Director
Colombian Health Association
(Asociación Colombiana de la Salud – ASSALUD)
Carrera 13 # 32-51- Office 918
Bogota
Colombia
franciscoy@cable.net.co
assalud@cable.net.co

Mamadi Yilla
Senior Policy Advisor
HIV/AIDS Interagency Coordinator, PEPFAR
United States Embassy
Lilongwe
Malawi
yillam@state.gov

Paul Zeitz
Executive Director
Global AIDS Alliance
1413 K Street NW, 4th Floor
Washington, DC 20005
USA
pzeitz@globalaidsalliance.org

WHO Secretariat
Hiroki Nakatani
Assistant Director-General
HIV/AIDS, Tuberculosis and Malaria
nakatanih@who.int

Anders Nordstrom
Assistant Director-General
Health Systems and Services
nordstroma@who.int

Denis Aitken
Representative of the Director-General
Partnerships and UN Reform
aitkend@who.int

Winnie Mpanju-Shumbusho
Senior Adviser to the Assistant Director-General
HIV/AIDS, TB and Malaria
mpanjuw@who.int

Nata Menabde
Deputy Regional Director
World Health Organization
Regional Office for Europe
Copenhagen, Denmark
nme@euro.who.int

Rufaro Chatora
Director, Aids, Tuberculosis and Malaria
World Health Organization
Regional Office for Africa
B.P. 6
Brazzaville
Republic of Congo
chatorar@afro.who.int

Subhash Salunke
The WHO Representative-Indonesia
PO Box 1302
Jakarta 10350
Indonesia
salunkes@who.or.id

Brenda Killen
Coordinator
Health Policy Development & Services
Services
Killenb@who.int

Phyllida Travis
Health Systems Adviser
Health Policy Development & Services
travisp@who.int

Diana Weil
Senior Policy Adviser
Stop TB Department
weild@who.int

Andrew Ball
Senior Strategy and Operations Adviser
Department of HIV/AIDS
balla@who.int

Badara Samb
Acting Coordinator
Systems Strengthening and HIV (SSH)
sambb@who.int

Global Fund Secretariat

Helen Evans
Deputy Executive Director
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Helen.Evans@TheGlobalFund.org

Stefano Lazzari
Senior Health Advisor
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Stefano.Lazzari@TheGlobalFund.org

Nosa Orobaton
Director Of Operations
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Nosa.Orobaton@TheGlobalFund.org

David Salinas
Manager, Business Strategy
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
David.Salinas@TheGlobalFund.Org

Ian Grubb
Adviser to Executive Director
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Ian.Grubb@TheGlobalFund.org

Karmen Bennett
Manager, Proposals Advisory Services
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Karmen.Bennett@TheGlobalFund.org

Johannes Hunger
The Global Fund to Fight AIDS,
Tuberculosis & Malaria
Johannes.Hunger@TheGlobalFund.org

Observers

Enrico Vicenti/Lucie Tagliaferri
Permanent Mission of Italy to the United Nations
Chemin de l'Imperatrice 10
1293 Geneva
Enrico.Vicenti@esteri.it

Kevin De Cock
Director
HIV Department
World Health Organization
decockk@who.int

Teguest Guerma
Associate Director
HIV Department
World Health Organization
guermat@who.int

Mario Raviglione
Director
Stop TB Department
World Health Organization
raviglionem@who.int

Sergio Spinaci
Associate Director
Global Malaria Programme
World Health Organization
spinacis@who.int

Awa Maria Coll-Seck
Executive Director
Roll Back Malaria Partnership
Secretariat (RBM)
World Health Organization
collsecka@who.int

Marcos Espinal
Director
Stop TB Partnership Secretariat (TBP)
World Health Organization
espinalm@who.int

Jorge Bermudez
Executive Secretary
UNITAID International drug purchase facility (UTD)
World Health Organization
bermudezj@who.int

Rania Kawar
Technical Office
Heath Systems Strengthening
World Health Organization
Kawarr@who.int

Annex 3
List of background materials

A Core materials

Background note 1 Decision point GV/B15/DP6: Global Fund strategic approach to health systems strengthening

Background note 2 Everybody's Business. Strengthening health systems to improve health outcomes, WHO 2007

Background note 3 Major health system constraints to improving HIV/AIDS, TB and malaria outcomes, and possible parameters for the Global Fund's response

Background paper 4: The Global Fund and health system strengthening: a short history

Background paper 5 Experiences of the GAVI Alliance Health System Strengthening Investment

B Additional background reading

Can be found on the following web page:

http://www.who.int/healthsystems/upcoming/en/index.html

Annex 4

The Global Fund's Strategic Approach To Health System Strengthening
Background note 3, July 30 - 31 2007 Consultation

Major health system constraints to improving HIV/AIDS, TB and malaria outcomes, and possible parameters for the Global Fund's response

Introduction

Debate on parameters for allowable health system strengthening (HSS) funding by the Global Fund has a long history. For this consultation it needs to be grounded in a common understanding of the major health system constraints that countries face in improving HIV/AIDS, TB and malaria outputs and outcomes. It needs to be underpinned by a recognition that the Global Fund can influence the development of health systems and services in two basic ways: through **direct funding**, and **more indirectly** through its impact on government policies such as cost recovery; the size of the workforce; the roles of different health workers; the role of the private sector etc. Both are important. This consultation is primarily about **direct investment**, but needs to take the Global Fund's indirect role, which is often overlooked, into account. Discussion also needs to take account of the diversity of countries eligible for Global Fund support.

This note is organised in three parts. First, it provides an overview of the biggest health system constraints or 'bottlenecks' faced by the three diseases. Second, it summarizes the nature of actions that are being supported by the Global Fund to overcome these constraints. Third, it sets out some options for defining appropriate parameters for Global Fund HSS investments, to stimulate discussion.

1. What are the biggest health system constraints to improved HIVAIDS, TB and malaria outputs and outcomes?

In any health system, good health services are those which deliver effective, safe, good quality prevention and treatment to those that need it, when needed, with minimum waste of resources. Effective delivery of HIV/AIDS, TB and malaria interventions requires staff with the appropriate knowledge and skills, plus medicines, diagnostics and equipment, working in an environment that provides the right incentives to providers and the population.

There are fairly consistent messages on the biggest constraints to improved HIV/AIDS, TB and malaria outputs and outcomes, from many different sources.

One source is the Fund's own analyses of problems with grant implementation. The constraints listed in box 1 have been identified as a common source of problems:

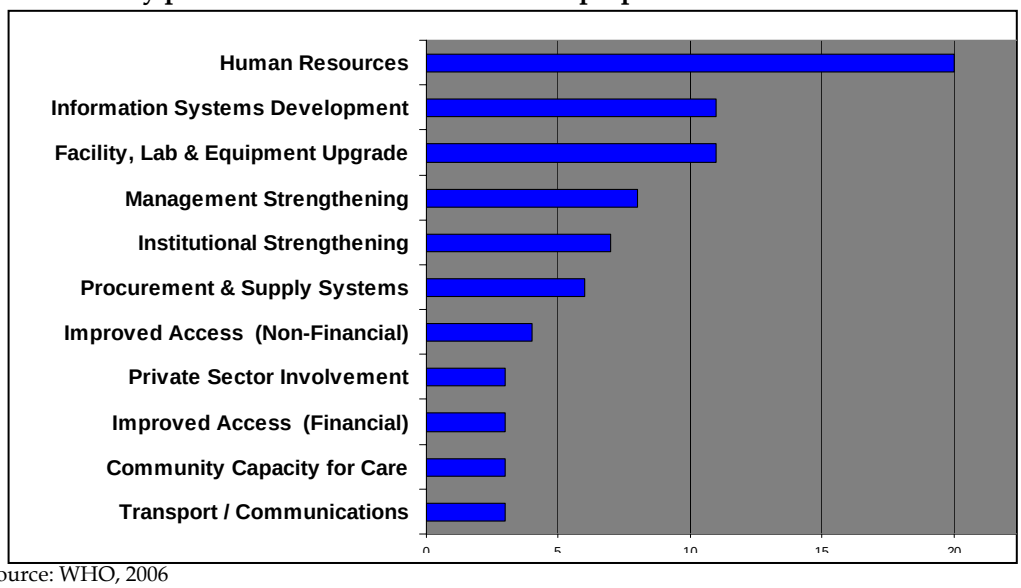
Box 1 GFATM grant implementation problems due to health system constraints

- health workforce mobilization, payment and management
- local management capacity in general, especially financial management
- infrastructure and equipment maintenance capacity
- monitoring and evaluation systems
- supply chain management
- financing mechanisms that constrain access or create impoverishment
- high level management capacity: for overall sector policy development; to manage multiple partners; manage relations with non health sector actors

source: Background document: Health System Strengthening; 3rd Portfolio Committee Meeting, 2006

A second source is countries' own perceptions of their greatest health system constraints to addressing HIV/AIDS TB and malaria. The diagram below provides an indication.

Box 2 Country priorities as articulated in 30 HSS proposals s in GFATM round 5



Source: WHO, 2006

These findings are echoed in an increasing number of international reviews of health system constraints to achieving the different health MDGs, and in additional discussions prior to this meeting. All agree more resources alone are not enough. A second key message is that similar health system constraints are encountered by almost every major health priority. For HIV/AIDS, TB and malaria, the repeated messages from multiple sources about the biggest and commonest constraints are summarised in box 3.

Box 3: Summary of the biggest constraints for HIVAIDS, TB, malaria

- Availability, skills and motivation of **health workers**
- **Drug procurement and distribution systems**
- **Diagnostic services**
- **Access** - especially financial access
- **Management and coordination of services**
- **Information and monitoring systems**

The relative importance and particular nature of a constraint will of course vary country by country. Applicants for funds have always been asked to identify programme needs, gaps and health system capacity in their proposals, but the request for an analysis of health system constraints is most explicit in the guidelines for round 7. Feedback on how this has worked should be available in the next few weeks.

2. Actions to overcome HSS constraints already supported by the Fund

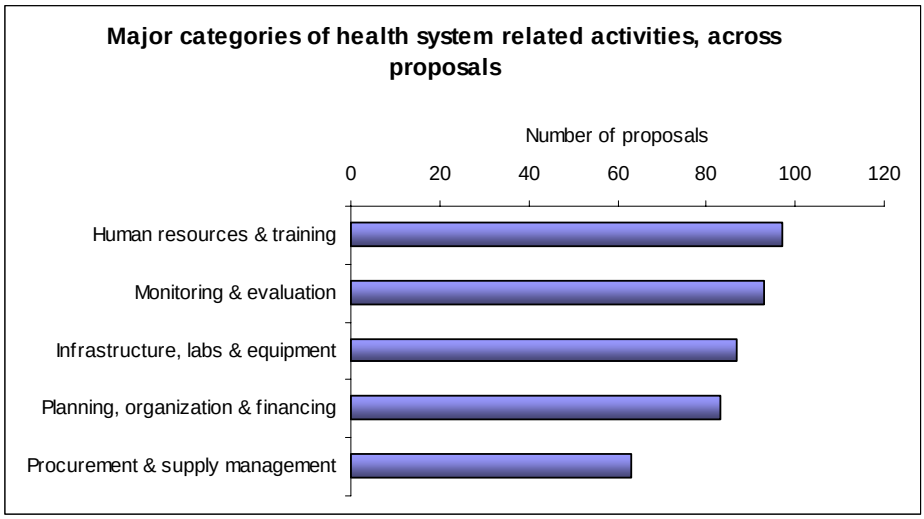
Within any of the broad thematic areas listed above, some constraints can be resolved by intervention at the service delivery level, while others can only be resolved by actions at higher levels of the system. Some can be addressed on a programme specific basis while others would benefit from greater coordination across programmes. There are some interventions that should almost always be tackled on a system-wide rather than programme specific basis. Not uncommonly, a package of interventions is needed.

One way of looking at what the Fund is doing on HSS is to look at its ***expenditures***. Within the Global Fund's seven budget categories, four (human resources; training; infrastructure and equipment; and planning and administration) are considered to contain 'a significant component of HSS expenditure'. For further information see background note 4 'The Global Fund and health system strengthening: a short history '.

It is useful to examine ***the nature*** of funded activities more closely. One crude but informative way is to review activities across approved proposals. The charts below

come from a review of 98 approved proposals in 21 countries. The way information is presented varies across proposals, is often limited and not always very concrete, so this is a purely descriptive analysis. Even so, the exercise gives some useful information. Broadly, Box 4 shows that the main activity groups reflect the major constraints. The pattern in box 4 was similar when analysed by disease component, except that laboratory strengthening activities were almost twice as common in TB proposals than in the others.

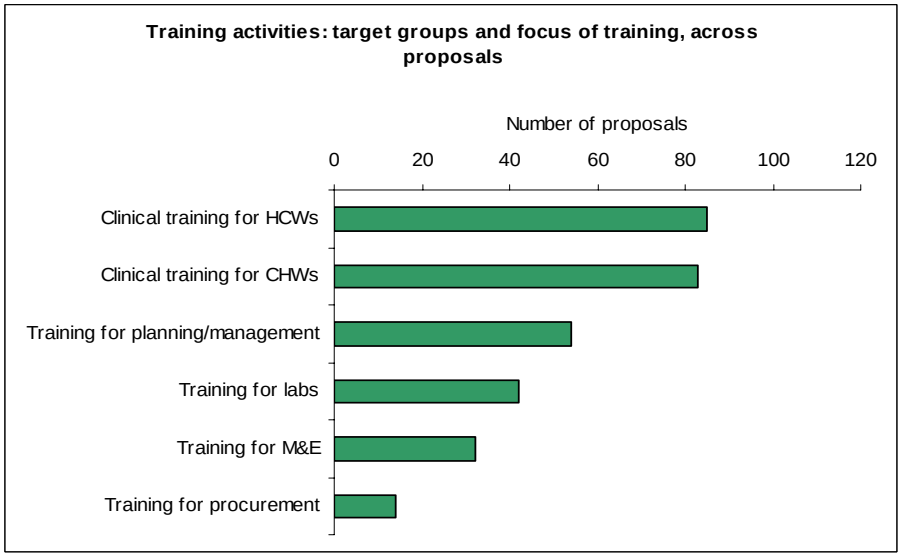
Box 4:



Source: Review of 98 approved proposals in 21 countries. WHO, 2006

Reviewing the nature of activities within these categories provides additional information. Within the 'human resources and training' group, all but 2 proposals have **training** activities; 80% include the production of **training materials,** and activities concerning planning and management are also common. Less than 50% have recruitment or remuneration related activities. In terms of **target groups for training**, box 5 shows that over 80% of proposals contain activities for clinical training of health care providers and community health workers. 14% of proposals contain training in procurement and supply management.

Box 5:



In summary, the types of activities are all essential actions designed to contribute to improved health systems and services. What is often less clear in the proposals reviewed is

- the extent to which the **mix of activities** funded constitute or are part of a **balanced package of interventions,** for example for health workforce development, that fit with national policy and strategy within the country concerned
- the extent to which these activities are expected to contribute to sustained improvements **across** services and outcomes

Another way of looking at the nature of HSS activities supported by the Global Fund is through individual country examples. The box below gives six examples in which the Fund has financed at least part of a country's response to an identified constraint.

Box 6: six country examples of HSS strengthening activities supported by the Global Fund

Country proposal	Definition of the problem in the proposal	Definition of the response, wholly or partly funded by the Fund
Malawi round 5 HSS	Argued, with supporting data, that the health workforce shortage was a key constraint to improving HTM outputs and outcomes but was too severe to be resolved on a disease specific basis	Asked the Fund to fund a portion of its costed emergency HRH plan, designed to implement the Malawi essential health package (which includes HIV/AIDS, TB and malaria). Plan includes both short and long term measures
Rwanda round 5 HSS	Argued, with supporting data, that overall low utilization of health services was due to financial barriers and poor quality, and these were critical obstacles to the success of HTM programmes	A package of measures that included the extension of ongoing community based health insurance to additional provinces; providing electricity to health centres in 6 provinces; and a mix of pre and in-service financial and HRH management training
Cambodia Round 5 HSS	Argued that Cambodia's achievements for HIV, TB and malaria have been at the cost of increased system fragmentation; noted Cambodia is seriously off track for maternal and child health MDG targets. Argued for integrating GF programmes with core MOH functions. Focused on 2 areas of fragmentation: health sector planning; procurement and distribution systems.	The response focused on activities to promote alignment of GF and other programmes with the Health Sector Strategic Plan; strengthen managers' planning, monitoring and evaluation mechanisms at all levels, and strengthen drug forecasting, procurement storage and distribution systems.
Kenya round 6 TB	TB is rising mainly because of HIV, and TB case detection remains low. Proposal argued that the most effective response, as stated in the national sector strategy and the TB plan, is by improving delivery of essential health services that include TB/HIV, at primary health care facilities. Argued that gains will not be realised if management capacity remains weak. Noted that a national HRH plan is still in development, & that districts have increased managerial responsibilities.	Focus of response: renovation of 33% of public dispensaries; some recruitment; accelerated activities to strengthen district level planning and management and HRH productivity. Aim is for all districts to have comprehensive health plans by the end of the 5 year grant. In the TB proposal, the MOH Planning and Health Sector Reform units are responsible for the Service Delivery Areas on district planning and management. Recruited lab techs will be trained in Kenya's essential lab oratory package.
Mozambique Round 6 HIV/AIDS	Argued, with supporting data, that constraints included inadequate infrastructure; scarce human resources; cumbersome HR management procedures; weak laboratory and drug procurement and distribution systems; referral constraints; coordination and management bottlenecks	Emphasized the integration of scaled up HIV services with existing out and in-patient services. One of the 5 objectives ('strengthen health systems'), included investing in pre-service training of basic and mid-level health professionals as part of a national HRH plan, and establishing 11 provincial HTM coordination teams.
Ethiopia	Early Fund grants for TB and malaria, and round 4 HIV, had large budget allocations for drugs and commodities. Ethiopia's national pharmaceutical supply service (PASS) was overwhelmed and slow. As a result, Fund disbursements were delayed. The MOH argued this was an opportunity to strengthen PASS, rather than bypass it - even temporarily.	While not part of a specific proposal to the Fund, these difficulties accelerated implementation of solutions to improve procurement and supply management procedures. Only a small amount of GF funds were used - to hire additional PASS staff to manage pharmaceuticals; vehicles, computers & office equipment - but with a major effect. By mid 2005, drugs and commodities were arriving at lower levels of the health system more reliably .

3. Clearer parameters for Global Fund support to overcome HSS constraints

As already stated, the Global Fund can influence health system development in two ways: through direct funding and through indirect influences. Both need to be kept in mind.

Some parameters for Fund investment already exist. Activities must clearly contribute to improving (and sustaining) HTM outcomes, in ways that strengthen health systems. Activities that are catalytic in nature, for example that encourage bridging opportunities across programmes where appropriate (such as HIV and reproductive health; blood safety) are allowable. Major infrastructure is excluded. The Fund's commitment to responding to country-defined investment could suggest that the Fund should not further 'cherry pick' areas for HSS investment. However, the lack of more specific parameters, or boundaries, has caused confusion: for countries in understanding what is 'allowable funding'; and for the TRP in reviewing proposals. Concerns about Fund mandate creep, and the sense that spending on health systems is a 'bottomless pit' have also repeatedly surfaced in Board meetings.

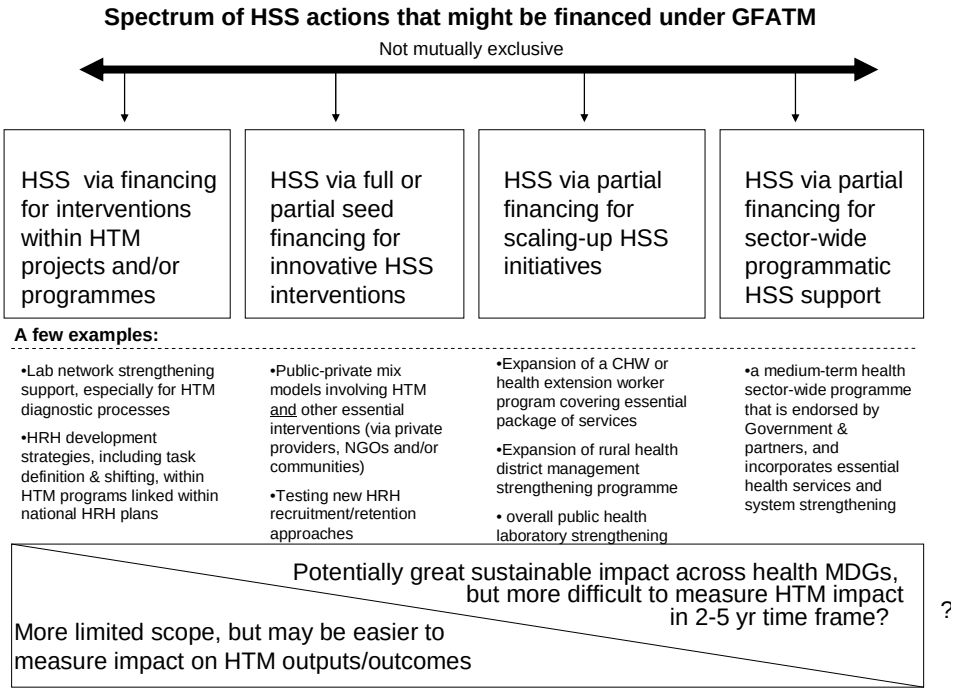
An increasing number of countries have credible national health sector strategies, Medium Term Expenditure Frameworks; national health workforce development plans etc. The costing of these and also disease programme specific plans is becoming more common place, though it is by no means universal. In line with its commitment to the Paris harmonization and alignment agenda, the Global Fund is already increasing its support for such 'programme based' approaches (a term which includes both technical programmes and sector programmes). Global Fund support to Mozambique and to Uganda are two examples of the latter. Partners need to have confidence in the strategies and plans to which they are committing support, and principles for validating such strategies and plans are currently being developed[5].

Where such strategies are not in place, the Global Fund can certainly **encourage their development**. In addition to doing this, an acceptable and workable approach to clarifying the scope of **what** the Fund can invest in and **how**, is needed. It needs to be as simple and flexible as possible. The rest of this note sets out a few ideas on possible approaches, for discussion at the consultation.

3.1 Parameters for 'allowable HSS activities' can be set in a number of different ways

- As a set of **'thematic' or focus areas -** for example, health workforce development; procurement and supplies management; diagnostic services; information systems
- Based on a particular **level** of the health system - for example, the primary focus of funding could be on activities that have a service delivery, or district level, focus
- By defining excluded or non-allowable activities more explicitly.
- By having greater clarity of what types of HSS activities it makes sense to fund on a programme specific basis, and what should be funded through other means - see Box 7.

[5] These include proposals from various bilateral donors, and the 'Health as a Tracer Sector' workstream for the Third High Level Forum on Aid Effectiveness to be held in Accra in September 2008



3.2 'Parameters plus': parameters need to be combined with a few principles….

However the parameters for allowable funding are eventually articulated, some additional features or good practice principles are needed for them to work as intended. The following are set out for discussion. They would apply whether or not there is a separate HSS component in Fund proposals.

1. **Parameters** should be considered as **a guide not a rigid blue print**. They must retain some flexibility to respond to different country circumstances, provided a compelling case is made in a proposal

2. Proposed interventions should be based on **best available evidence.** Such knowledge is increasing but it could be made more readily accessible. Box 8 gives one example. It is a draft framework, being developed by GHWA and WHO from an analysis in eight low income countries, that could be used as an 'aide memoire' for developing or reviewing proposals concerned with scale up of health workforce education and training.

Box 8 Draft framework for successful country scale-up of health workers education and training

- Political will, including sustained government involvement and support
- Government commitment to short and long-term workforce planning
- Collaboration between several partners including government actors; professional groups, providers and donors
- Significant financial investment, including government and if necessary donor budgets
- Commitment to fill the gap with appropriately trained health care workers
- Focus on health outcomes in the choice of types of workers to be produced, and a multi-skilled team
- Significant expansion of pre-service training capacity for all types of workers, including management and administration
- Strengthened health workforce management and leadership
- Health information systems producing reliable health and health workforce data
- A labour market with the capacity to absorb and retain new health workers, and ensure productivity

3. Proposals should build on wide experience of **good strategy design**
The effects of similar interventions can vary in different settings, and can be unpredictable. However, in many instances there are some reasonably well-accepted 'good' design principles to enhance system-wide positive effects.

Box 9: Proposal design principles: some examples of do's and don'ts

DO

- Build on existing primary level services, support systems, training approaches and materials to the maximum extent possible. Where this is not possible in the short run, have a plan of how to do so in the longer run
- Ensure proposed activities constitute or are part of a balanced package of interventions, and fit within a national strategy where it exists
- Think through the implications of programme-specific activities for other national health priorities and services - for example the effects of individual programme incentives
- Set out the actions to be taken to mitigate any possible negative effects

DON'T

- Develop separate financing systems for individual services or programmes
- Demand data outside national plans; unreasonably frequent reporting
- Forget to keep an open mind, and look out for unintended as well as intended effects
- Forget to think of investments that reflect the Global Fund's comparative strength but would benefit all programmes and services

---

4. A sense of **costs** is needed
   There are many different ways of looking at costs, that serve different purposes. Global price tags, for example for the health workforce crisis, or the overall resource envelope for meeting the health MDGS, generate much needed attention to a problem but can also generate alarm and resistance in Ministries of Finance. Some cost estimates are based on what it would cost to entirely eliminate all constraints, while others focus on costing a reduction of selected constraints. The costs of 'unblocking' some bottlenecks can be large, but the costs of removing others can be rather small - for example, funds for fuel to carry out supervisory visits. Pooling of resources may allow funds to go further. The well-known TEHIP project in Tanzania estimates that its impressive gains in child survival were achieved with an extra US$0.80 per person per year. It was the flexibility given to district teams in the use of their additional funds, which they spent on a package of often unspectacular but effective actions, that was more important. The costs of certain types of 'catalytic activities' may also be fairly small - e.g. seed funding to develop a workforce strategy - but may help release a much larger tranche of funding from elsewhere.

   Realistic cost estimates - maybe for several different 'scale-up' scenarios - provide a basis for debate and agreement with key stakeholders. Subsequent financing can then be mobilised from multiple sources. One of the factors behind Malawi's success with its Emergency Human Resource Programme , which was costed at US$272 million, was that it was based on what was thought to be an ambitious but attainable goal of raising Malawi's staffing to Tanzanian levels over six years. It was subsequently funded by the Government of Malawi, DFID and the Global Fund.

5. **Confidence** that returns from investment are possible, within a reasonable **timeframe.**
   Some HSS activities take time to deliver results, but others can generate returns relatively quickly. Two examples are given here. *Malawi's* six year Emergency Human Resources Programme began in April 2005. It has a five pronged approach that includes salary top-ups. It aims for short term improvements while pursuing longer term goals. Nine months later a positive impact could already be seen: 430 more employees were receiving salary top-ups. Health managers thought the top-ups were the main factor in stemming the flow of staff, especially nurses, from the public sector. In *Tanzania*, there have been rapid national gains in child survival between 1999 and 2004. Preliminary assessment suggests that a series of health systems events have contributed to improved coverage of essential interventions: SWAp and basket funds; increased public spending; improved planning and management; an increased drugs budget; innovative approaches to expanding bed net distribution and malaria treatment. There is optimism that the trend will continue.

6. **Credible metrics** exist for tracking changes in health systems performance
   Tracking progress is a key element of good practice, for two reasons: for good management - allowing timely 'course corrections' to be made if needed; and for accountability. A health system monitoring system needs to capture trends in health system inputs and outputs, supported by coverage data with a small set of indicators. Progress can be summarized with a **country health system metrics dashboard** that

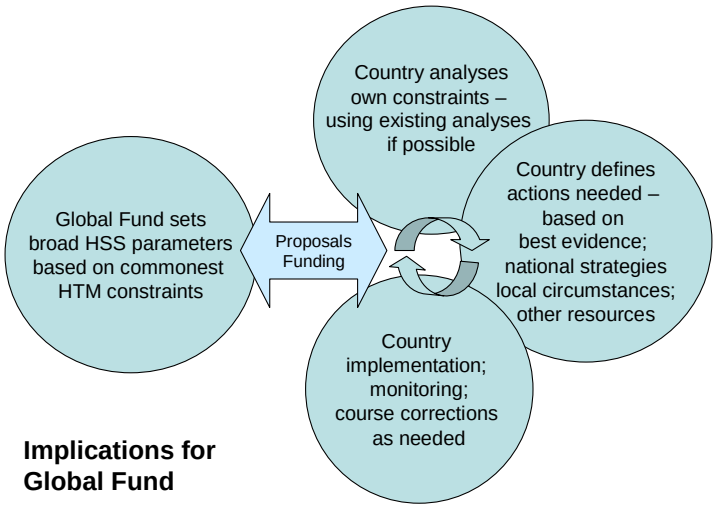
includes key indicators for these core areas and describes progress on an annual or bi-annual basis. An international meeting organized by the Health Metrics Network and WHO in 2006 took stock of the status of indicators and measurement methods and developed guidance for the potential contents of a dashboard[6]. Around 50 countries are engaged with HMN, and are also in the process of assessing their information systems and developing their individual Health Information System development 'road maps'.

7. The **process** of proposal development, not just its technical content, is critical to achieving effective implementation. The short GAVI note provides lessons from its recent experience with the GAVI HSS window.

8. Lastly, mutually acceptable ways (to countries and to GHIs) to **channel funds is needed** Session 6 will focus on this.

In summary
This note is designed as a starting point for discussion at the consultation. There are consistent messages about the biggest health system constraints to improving HIV/AIDS, TB and malaria outcomes. In determining any response, it is important to remember that a health system, like any other system, is a set of inter-connected parts. Changes in one part will have repercussions elsewhere, which may be positive or negative. Second, in whatever way the parameters are finally framed, there will be practical implications to consider: for the Fund, for countries and for partners. Box 10 sets out a framework for considering these implications.

Box 10



Implications for partners

Better guidance and support for constraints analysis if needed

Better access to current international evidence; costing tools etc

Health system metrics for tracking progress operational

Implications for Global Fund

Proposal form design

TRP membership

TRP review procedures

Implications for countries

Country proposal processes
include appropriate spectrum of stakeholders

[6] http://www.who.int/healthinfo/health_system_metrics_glion_report.pdf

Annex 5

The Global Fund's Strategic Approach To Health System Strengthening
Background note 4, July 30 - 31 2007 Consultation

The Global Fund and health system strengthening: a short history

This paper summarizes the Global Fund to Fight AIDS, Tuberculosis and Malaria's (Global Fund) experience in funding health system strengthening (HSS) activities. It is based on previous Global Fund documents, and incorporates more recent experience.

I. Global Fund mandate

The Global Fund's founding principles, as set out in the Framework Document, state that the Fund will:

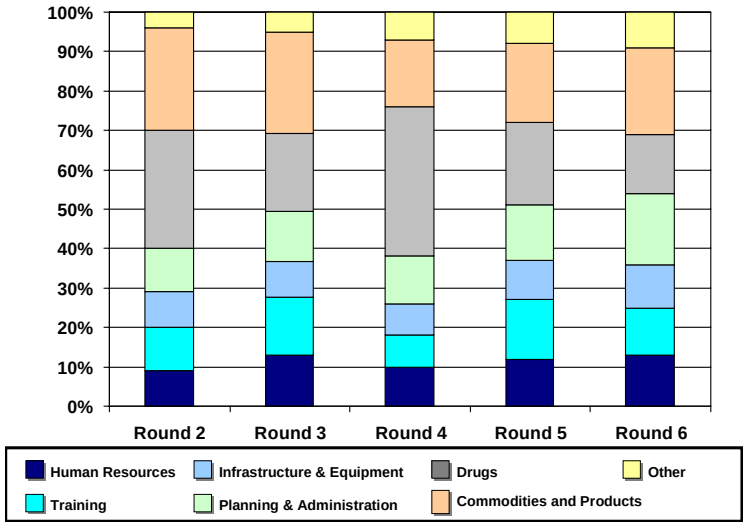
- Support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector; across government departments and with communities; and
- Support programmes that address the three diseases in ways that will contribute to strengthening health systems.
- Support performance based funding, and a focus on results

The key issue is therefore not *whether* the Global Fund should invest in strengthening of health systems, but rather *how* it can best do so.

II. Global Fund expenditures on health system strengthening

Out of the Global Fund's seven budget categories, four categories may contain significant components of HSS expenditure: human resources; training; infrastructure and equipment; and planning and administration (shown here in blue and green). Trends by budget category over 5 proposal rounds are shown in box 1.

Box 1: Trends in Global Fund expenditures



III. Global Fund application processes for health systems strengthening

Over the seven rounds there have been a number of variations in how to apply for funds for HSS activities.

- In Rounds 1-3, applicants had the option of applying for HSS expenditures through a 'cross-cutting' (or "Integrated") component in addition to the three stand alone disease-components (plus HIV/TB component). Applicants were able to request funds through this integrated component for programmes addressing system-wide or 'cross-cutting' issues relevant to the fight against the three diseases. Rounds 2 and 3 guidelines stated that 'where relevant', intervention strategies for the three diseases should be integrated to maximise available resources.

- Round 4 continued the specific "Integrated" component but with increased information to applicants on what could be requested. Guidelines defined this as "a comprehensive response to the three diseases that focuses on system-wide approaches and cross-cutting aspects to strengthen health systems".

- Round 5 introduced a separate "Health Systems Strengthening" component, to improve upon and clarify the "Integrated" component in Round 4. In practice, the guideline definitions for both were very similar.

- In Round 6, there was no separate component for HSS. Applications for activities to strengthen health systems could only be included within the disease component for which such activities were deemed necessary.

- Round 7 used the same approach as Round 6, but introduced the notion of a health system 'strategic action' within a disease component. Round 7 guidance more explicitly allows applicants to request funding for cross-cutting HSS actions that will benefit other components, whether or not these are included in the application, provided that there is no duplication of funding requested.

IV. Global Fund guidance on allowable activities: scope and trends

There has been a significant evolution in the Global Fund's guidance for applicants.

1. The readiness to provide grants to public, private and non governmental programmes to address the three diseases in ways that contribute to health systems strengthening, and the need to consider how to sustain results, has been explicit in all rounds.

2. In terms of ***directly funded*** HSS activities, the implicit scope of allowable activities has remained largely the same over succeeding rounds, but examples of the types of activities that the Global Fund is willing to fund have become more extensive and explicit, in efforts to provide greater clarity. (See table below)

Round	Examples of allowable HSS activities, given in guidelines
1	Guidelines state any proposed actions must be shown to be linked to achievement of clear, measurable and sustainable HIVAIDS, TB and malaria outputs and outcomes. One explicit example given: strengthening of comprehensive commodity management systems at country level.
2	Four examples listed: actions that enhance increased access to health services; recruitment and training of personnel and community health workers; strengthening of comprehensive national commodity management systems; strengthening of information systems
3	Same as above, but expanded the examples of allowable health workforce activities to include interventions to improve deployment and supervision
4	Four areas mentioned: human capacity development (including training and compensation for both technical and managerial staff, in public and private sectors); procurement and supply management systems; monitoring and evaluation systems; coordination
5	Same four areas, plus operational research (check wording)
6	11 examples; with proviso that these include but are not limited to: HRH mobilization, training and management capacity development; general local and high level management capacity development; infrastructure renovation; equipment maintenance capacity; health information systems; supply chain management; innovative financing mechanisms; engagement of community and non state providers; quality of care management; operations research
7	15 examples of HSS strategic actions: governance; strategic planning & policy development; monitoring and evaluation; coordination / partnerships; community and client involvement; policy research; information systems; health management; health financing; human resources; essential medicines and other pharmaceutical products management; procurement systems; logistics including transport and communications; infrastructure (excluding large scale investments); technology management and maintenance.

3. While proposals have always been required to base their plans on an analysis of technical programme need, from Round 5 guidelines have explicitly required any proposals to be based on a comprehensive review of 'health system capacity' (both public and private). In Round 7 the wording is for proposals to be based on an analysis of health system constraints.

4. Round 7 emphasized for the first time a request for applicants to demonstrate that they had thought through the ***implications of proposed activities on other health services***, and had plans for risk mitigation where needed.

5. Over succeeding rounds there has been an ***increasing emphasis on alignment with national policies and processes***, with more explicit requirements for proposals to situate proposed activities within the broader national context; to explain how they complement and align with national health sector strategies and broader development frameworks; and to demonstrate synergies and linkages with existing grants and to other related donor-funded programmes. Round 6 and 7 proposal forms contained a section for those wanting to use common funding arrangements as the channel for receipt of Global Fund additional financing.

V. Lessons from experience, with a focus on Rounds 5 and 6

Rounds 1 to 4 'integrated' proposals had low application and low success rates: only one proposal was approved out of a total of ten submitted.

In Round 5, out of 30 applications for the 'HSS' component, only three were approved (10%).

Observations from the TRP
The TRP observed that the successful HSS proposals, which covered different dimensions of health systems, shared characteristics of other successful proposals: they were generally focussed on a small range of activities; were judged to be realistic; had clear objectives, strategies and activities which were linked to coherent budgets and work plans. They made a compelling case for the HSS activities, and argued this would contribute to the fight against one or more of the diseases. Unsuccessful proposals tended to be too broad and ambitious, too vague in their objectives, proposed activities, and with poor work plans and/or budgets.

Nevertheless a greater proportion of HSS than disease specific proposals were judged below standard. While some have argued that this was the first time, and - as happened with disease components - the quality could be expected to improve in subsequent rounds, there were TRP observations specific to the HSS component that suggested this would not be automatic.

- The definitions of what constitutes an HSS proposal were too vague and too broad with little guidance to applicants on any specific focus.
- The proposal form was originally designed for the disease specific components and was largely unsuitable for the submission of HSS proposals.
- Insufficient guidance was provided on what an effective linkage between HSS and a disease component should or could look like. In many proposals, these linkages were superficial and not convincing.
- There was insufficient clarity on whether to include HSS elements only in the HSS proposal or in both HSS and disease-specific proposals. This had the obvious downside of potential duplication between two successful applications, or in few cases, a disease component was recommended for funding but was contingent for successful implementation on resources applied for in an unsuccessful HSS component.
- The Global Fund system is not currently set up to generate strong HSS proposals nor to evaluate these effectively.
-

In Round 6, in which HSS elements were reintegrated into the disease specific components on recommendation of the TRP, the TRP had the following observations on HSS:

- The overall quality of the HSS elements proposed within the many of the Round 6 proposals remained low.
- There remained a lack of justification for proposed HSS activities on the basis of specific constraints faced by countries.
- As in the previous round, proposals were too broad, ambitious and vague in their objectives and/or proposed activities, work plans and budgets.
- The failure of many proposals to locate specific proposed HSS strategies within the broader national context made it difficult for the TRP to assess their likely impact on disease-specific targets and on the broader healthcare system.
- Some proposals suggested HSS activities that were very likely to undermine other elements of the healthcare system.

The TRP made the following recommendations

- The Global Fund needs to **define the scope, boundaries** and extent of activities that it is willing to fund under the rubric of HSS activities. The broad scope in Round 6 created difficulties for countries in focussing their proposals and caused significant problems for the TRP in evaluating such proposals.
- Any process to clarify the scope of HSS activities would **need to ensure harmonization and consistency** between the Global Fund's HSS mandate and those of other technical partners and agencies.
- Activities that fall within the scope of Global Fund mandated activities must be located **within national policies, plans and standards**, and justified in terms of disease specific targets. [It suggested criteria for HR activities, equipment and infrastructure].
- There is a need for more specific guidance to applicants to provide a clear explanation of **HSS related constraints**, and how proposed activities will address them; and on the nature of **linkages** between HSS elements and the disease proposal.
- There is a need for the Global Fund to work with its partners to develop an agreed harmonized **toolkit of monitoring indicators** to track the results of investments in HSS elements and for applicants to be guided to include these within their proposals in future funding Rounds.

The TRP also suggested that, as part of the Secretariat's agenda of working to strengthen CCMs, it consider CCM capacity to develop/oversee proposals with stronger HSS elements.

Conclusion

The Global Fund Board, its Committees, the TRP, the Secretariat, country applicants and supporting advisers have all wrestled with how to define, interpret or apply the guidance on the ways in which the Fund can support the strengthening of health systems. The debate has been influenced by a wealth of studies and by developments in other agencies, many of whom who have been re-examining their role in the international health system agenda. Another significant development has been the Global Fund's commitment to the Paris Principles of Harmonization and Alignment. If taken to their logical conclusion, these will also have a major influence on how the Global Fund supports health system strengthening.

Annex 6

The Global Fund's Strategic Approach To Health System Strengthening
Background note 5 for July 30 - 31 2007 Consultation

Experiences of the GAVI Alliance Health System Strengthening Investment

1. WHAT IS THIS?

This background paper shares the experiences of the GAVI Alliance Health Systems Strengthening (HSS) investment in terms of history, principles, processes, analysis of proposals and lessons learnt. It has been drafted by the GAVI Secretariat in preparation for the consultation on the Global Fund's Strategic Approach to Health System Strengthening 30-31 July 2007 and forms the basis for a presentation that will be made at the meeting.

Reference documents made available include:

a) GAVI Alliance 2007 HSS guidelines and application form[7]
b) Original GAVI HSS investment case approved by the board in December 2005
c) GAVI HSS board updates January 2006 and May 2007
d) GAVI HSS task team Terms of Reference 2007

2. JUSTIFICATION FOR A SEPARATE GAVI HSS FUND AND BOARD APPROVAL

It must first be emphasised that the GAVI and GFATM business models are different. It may therefore not be possible to draw comparisons for what is 'right' for GAVI and what is 'right' for GFATM. However equitable, efficient and effective delivery of any 'health package' such as basic, new or under-utilised vaccines cannot be in isolation and needs to be seen in the context of an integrated, strong health system. Health system barriers / bottlenecks need to be identified and addressed if there are to be sustainable increases in vaccination coverage. These barriers / bottlenecks are often the same as those for delivering other child health packages and therefore overcoming them is crucial for achieving MDG 4.

In 2004, the GAVI Secretariat commissioned a study to review the key barriers to increasing immunisation coverage. This study revealed that the barriers were broader than the immunisation system alone and included health workforce allocation and motivation, transport, fund flow to peripheral levels and planning and management at peripheral levels. Also acknowledging that GAVI's investment in new vaccines needs to be balanced with investment in strengthening delivery mechanisms, this study helped stimulate the drafting of an investment case for a separate funding window on health systems strengthening (HSS).

An initial reference group[8] was constituted which helped design the HSS investment case throughout 2005 and this was presented to (and approved by) the GAVI boards in December 2005. Although the initial approval for a separate HSS investment was $500 million for 2006 - 2010, the time horizon is for 2015, pending results of an evaluation in 2010.

Risks acknowledged: Many board members recognise the need for this investment and acknowledge that it is more 'risky' than other GAVI portfolio investments. Measuring attribution may not be possible, robust monitoring and evaluating processes need to be designed, best practices need to be documented, countries need to drive processes forward and steps need to be put in place to increase financial accountability and transparency.

3. ELIGIBILITY, BUDGET AND GUIDING PRINCIPLES

[7] http://www.gavialliance.org/Support_to_Country/Forms/index.php

[8] Membership included developing countries, WHO World Bank, Unicef, USAID, Vill and Melinda Gates Foundation, DANIDA, civil society, Norad, CIDA, DFID, PATH, Aventis, HLSP consulting and the GAVI Alliance secretariat

Eligibility criteria: All 72 phase-two GAVI eligible countries are eligible for HSS funding. Only national Governments may apply, although some exceptions may be considered for fragile states. Countries should have completed a costed immunization comprehensive Multi Year Plan on immunization (or its equivalent) for the duration of the HSS proposal. GAVI HSS funds should not be used to purchase vaccines and should be in addition to (not displace) existing budget lines.

GAVI HSS budget 'envelopes' for countries: The duration of the GAVI HSS proposal should be aligned with the duration of the country's health sector plan (or its equivalent). The country's potential budget envelope is calculated as follows:

- Countries with a GNI per capita <$365 per year - eligible for $5 per newborn per year.
- Countries with a GNI per capita >$365 per year - eligible for $2.50 per newborn per year.

What can a country apply for? As long as a country meets the eligibility criteria (above), GAVI HSS funding should target the "bottlenecks" or 'barriers' in the health system that impede progress in improving the provision of and demand for immunisation and other child and maternal health services. The impact should be at peripheral and service delivery level. Although three non-exclusive themes are suggested (health work force, organisation and management at district level and below and supply, distribution and maintenance systems) HSS funds may be considered to fund other activities that have been identified as a priority by the national government to overcome health system barriers to increasing immunisation coverage.

Guiding principles: 10 guiding principles are outlined on pages 4 and 5 of the HSS guidelines. Four are important to highlight:

i) **Country driven approach:** The countries needs and direction should guide the direction of the HSS design and it is up to the Secretariat and Alliance partners to respond to these needs. This obviously also increases country ownership.

ii) **Alignment:** Any GAVI HSS investment should be aligned with the objectives, strategies and planning cycles of existing Government health sector policies and frameworks

iii) **Inclusive and collaborative:** All key stakeholders in health system strengthening (beyond the immunisation programme) should be involved in GAVI HSS. Government entities, partners, civil society, and the private sector should all be informed and involved, as appropriate, in the planning, implementation and evaluation stages.

iv) **Performance based:** The linkage to EPI and EPI coverage as the main outcome ensures that the proposals are performance oriented. This should be maintained within the larger health systems initiative.

4. GAVI HSS COORDINATION MECHANISMS

Three main coordination challenges include: i) ensuring that global level and country level coordination mechanisms provide added value to the implementation of the HSS window; ii) strengthening linkages between immunisation programmes and health systems strengthening and iii) strengthening linkages and sharing experiences with other initiatives involved with health systems strengthening.

GAVI Alliance HSS task team: Implementation of the GAVI Alliance HSS investment receives guidance and recommendations from a global level GAVI HSS task team. This 10 member task team is co-chaired by the 3 multilaterals (WHO, UNICEF and World Bank) and has representation from DFID, NORAD, USAID, developing countries, civil society, Bill and Melinda Gates Foundation and the GAVI Alliance Secretariat. Despite each institution having different paradigms for health systems strengthening and the difficulties in reaching consensus in such a diverse group of partners, the task team has drafted communal work plans and designed and greatly assisted the implementation of the GAVI HSS opportunity. Through its co-chairing mechanism, this entity has also helped strengthen the coordination, cooperation and information flow between the three multilaterals on health systems strengthening issues.

Country coordination mechanisms: Use of existing national health sector coordination mechanisms at country level[9] for the drafting, implementation and monitoring of the GAVI HSS proposal. The proposal should be within the context of other ongoing health sector activities and planning processes. The GAVI HSS proposal development process has helped bring partners involved with HSS together.

Strengthening linkages between EPI and health systems strengthening: Although there have been some issues of fund control and proposal writing in some countries, in general the emphasis has been on encouraging planning departments to take the lead with technical inputs from EPI departments. This has helped increase mutual understanding and often empowered departments of planning.

Strengthening linkages with other initiatives: In the spirit of the Paris Declaration, other initiatives[10] involved with health systems strengthening have been included in information sharing and invited to various GAVI HSS meetings to provide inputs. Three joint country visits have been undertaken with GFATM and two of these visits also included HMN.

5. PROPOSAL DEVELOPMENT, GUIDELINES SUBMISSION, REVIEW AND FUND FLOW PROCESSES

Proposal development grant: Countries have access to a grant of up to $50,000 which is meant to assist countries with stakeholder consultations, and drafting a proposal that aims to overcome some of the health systems barriers. Many countries have not accessed this funding yet, but used other sources in the meantime and also used existing health system and EPI reviews. Although these grants were meant to stimulate the support of in-country and regional support for technical assistance, 43 of 49 countries applying for this grant have asked for funds to be channelled through WHO and used international consultants to help draft their proposals.

Guidelines: The 2006 HSS guidelines and application form received much feedback from partners and countries and these were revised for 2007 on the basis of this feedback. The guidelines highlight the principles and practice of GAVI HSS.

Review process: When a proposal has been drafted in-country it is expected that an in-country review takes place that helps not only make the proposal more technically robust, but also ensures stakeholder 'buy in' to the process. In the future there might be an opportunity for regional peer review, where countries are able to review each others proposals and make comments before submission to the GAVI Secretariat. Once a proposal has been submitted to the GAVI Secretariat it is 'pre-reviewed' by WHO to ensure consistency, completion and cross checking of figures and documentation. Proposals are then reviewed by an Independent Review Committee (IRC) of 10 people (9 reviewers and 1 chair) who make recommendations to the Board for approval or not. There have been 3 rounds of HSS proposals since last November and their financial overview is in annex 1.

Approval and fund flow: Once a proposal has been recommended for approval to the board and if the board approves it, funds are expected to flow to the country within 8-12 weeks. Much of the HSS funding will come from the International Financing Facility for Immunization (IFFIm) and this mechanism requires a separate board meeting in itself.

6. 31 GAVI HSS PROPOSALS RECEIVED SO FAR

Of the 31 new country proposals submitted to the GAVI Secretariat, 16 have been approved for funding (details in annex 1) and these approved proposals are available on the GAVI Alliance website. An in-depth analysis of bottlenecks identified and activities supported by

[9] Such as the Health Sector Coordination Committee

[10] GFATM, HMN, Global Health Workforce Alliance, Stop TB and others

GAVI HSS funding will be undertaken and made available for the board meeting in November and after each round in 2008. Most health system bottlenecks are related to human resource shortages or training, infrastructure weaknesses, transport or management and coordination at peripheral levels.

7. LESSONS LEARNED

Need for quality technical support: All countries identify the need for quality technical support (to assist in developing and implementing proposals) that is delivered in a locally appropriate way. However, scaling up any institutional capacity to respond to this need without the usual reliance on international consultants remains challenging. The long term GAVI HSS support provides an opportunity to support national and regional institutes to provide technical assistance in a more sustainable and locally appropriate manner.

Country driven and learning approaches: Each country is different and has its own bottlenecks to deliver services. There is no 'one size fits all' and putting the countries 'centre stage' has helped drive processes forward to strengthen partner support. By documenting lessons learnt and identifying best practices, the GAVI HSS opportunity remains flexible and changes according to 'what works' and what does not. It should be noted that the business model used by the GAVI Alliance is very different to that of the GFATM.

Coordination structures: The GAVI HSS coordination structures at global and country levels have been extremely important in pulling partners together and ensuring information flow.

Paris Principles: The GAVI HSS is attempting to 'operationlise' the Paris Principles. The lessons learned are all useful feedback for other initiatives that may try and operationalise the same principles. However, some have expressed the concern that some countries may view proposals that have been approved as a 'blue print' for successful funding and 'cut and paste' inappropriate strategies into their own country proposals.

Review of proposals: There is no 'perfect' way of reviewing complex proposals. The GAVI HSS IRC has had to strike a balance between an academic / technically robust method and pragmatic need to investment in health systems with proposals that can be implemented in the world's poorest countries. The IRC method of review has had to be adaptive and responsive to needs.

8. CHALLENGES

Different paradigms of HSS: Consensus on HSS may not be possible amongst Alliance partners and the Secretariat, but by putting the countries needs centre stage and continuously learning and reviewing country needs and identifying best practices, this ensures that partners respond to a process that is being driven by countries.

Need for clear concise guidelines and application guidelines: The proposal drafting and review processes are directly linked to the clarity of the guidelines and ease of filling in the application forms.

Monitoring and evaluation: As the GAVI HSS support is such a country driven approach, each country's proposal and therefore indicators are different. Some countries may use a basket funding approach which makes it difficult to measure any attribution of the GAVI HSS funding. Measuring impact and ensuring the evaluation planned in 2009-2010 will help guide the boards on further potential investment. This will be a key piece of work. The monitoring IRC will countries annual progress reports and decide whether countries have reached their stated objectives. As impact indicators may not be reached for several years, it may be difficult to measure the actual implementation for several years and perhaps the first few years may be viewed as an 'investment'.

Operational Research: Despite operational research being promoted within country applications, very few countries have taken advantage of this opportunity. It is therefore suggested that global level initiatives and literature reviews help provide evidence based materials to guide country policy and decision makers

Accountability and risk mitigation: Steps are being taken to put in place mechanisms that will reduce the chances of mismanagement of funds.

Relatively small budget compared to the need of the sector: Despite great expectations of the flexible GAVI investment, the budget is small in comparison to the needs.

ANNEX 1 Financial overview of GAVI HSS approvals over 3 rounds

HSS Approvals for 3 Rounds

Country	2007	2008	2009	2010	2011	Total
Round 1						**$92,112,500**
Burundi	$2,704,000	$2,274,000	$1,754,000	$760,000	$760,000	$8,252,000
Cambodia	$1,850,000					$1,850,000
Ethiopia	$55,839,500	$12,629,500	$8,025,500			$76,494,500
Korea DPR	$450,500	$1,308,000	$1,027,000	$1,026,000	$549,500	$4,361,000
Kyrgyz Rep	$424,000	$255,500	$255,500	$220,000		$1,155,000
Round 2						**$77,625,000**
Congo DR	$21,526,000	$15,717,500	$11,910,000	$7,661,000		$56,814,500
Georgia	$69,000	$122,500	$122,500	$121,500		$435,500
Liberia	$1,022,500	$1,022,500	$1,022,500	$1,022,500		$4,090,000
Vietnam	$3,648,000	$4,705,000	$4,439,000	$3,493,000		$16,285,000
Round 3						**$95,919,500**
Afghanistan	$6,700,000	$8,950,000	$7,200,000	$6,600,000	$4,650,000	$34,100,000
Cameroun	$1,858,000	$1,912,000	$1,967,500	$2,024,500	$2,084,000	$9,846,000
Kenya	$3,741,500	$2,964,000	$3,197,500			$9,903,000
Pakistan		$16,898,500	$6,626,500			$23,525,000
Rwanda	$2,174,000	$1,715,500	$1,715,500			$5,605,000
Yemen	$376,000	$2,198,000	$2,188,000	$1,573,000		$6,335,000
Zambia	$2,344,500	$573,000	$2,396,500	$1,291,500		$6,605,500
Grand Total	**$104,727,500**	**$73,245,500**	**$53,847,500**	**$25,793,000**	**$8,043,500**	**$265,657,000**

Proposal Summary	Submitted	Approved	Conditional	Resubmission	Conditionals approved
	31	12	8	11	4