GAVI/13/355/sc/cw

HE Dr Agnes Binagwaho
The Minister of Health
Ministry of Health
PO Box 84
Kigali
Rwanda

6 June 2013

Dear Minister,

Rwanda's application to the GAVI Alliance for health system strengthening support

I am writing in relation to Rwanda's proposal for health system strengthening cash support which was submitted to the GAVI Secretariat in February 2013.

Following a meeting of the GAVI Independent Review Committee (IRC) from 4 to 12 April 2013 to consider your application, we are pleased to inform you that the GAVI Alliance has approved Rwanda for GAVI's health system strengthening (HSS) support. The terms of this grant are as specified in the Appendices to this letter.

We would like to remind you that GAVI's HSS support for your approved application will be implemented in accordance with GAVI's performance based financing (PBF) approach. This is in compliance with the GAVI Board decision in November 2011 to roll out PBF as the default mode of cash-based support for HSS from 2012. PBF is designed to link cash support to performance, thereby providing incentives for better immunisation outcomes through strengthening health systems. Please see Appendix C for additional information.

Please do not hesitate to contact my colleague Charlie Whetham at cwhetham@gavialliance.org or email gavihss@gavialliance.org if you have any questions or concerns.

Yours sincerely,

Hind H. Khatib

Hind Khatib-Othman
Managing Director, Country Programmes

Attachments:
Appendix A: Decision Letter for HSS Cash Support.
Appendix B: Report of the Independent Review Committee.
Appendix C: GAVI's HSS cash support: Performance based funding (PBF)
Appendix D: GAVI Alliance Terms and Conditions

cc:
The Minister of Finance
The Director of Medical Services
Director Planning Unit, MoH
The EPI Manager
WHO & UNICEF Country Representative
WHO HQ
UNICEF Programme Division

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APPENDIX A

This Decision Letter sets out the Programme Terms of a Programme

1. **Country:** Rwanda
2. **Grant number:** 1317-RWA-10d-Y
3. **Decision Letter number:** 2
4. **Date of the Partnership Framework Agreement:** N/A – not signed yet
5. **Programme Title:** Health Systems Strengthening (HSS)
6. **HSS terms:**

The ultimate aim of HSFP support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in:

- The GAVI HSFP guidelines
- The GAVI HSFP application form
- Country's approved grant proposal and any responses to the HSFP IRC's request for clarifications.

Any disbursements under GAVI's HSS cash support will only be made if the following requirements are satisfied:

- GAVI's availability of funding;
- Submission of satisfactory Annual Progress Reports (APRs) by Country;
- Approval of the recommendation by an Independent Review Committee (IRC) for continued support by GAVI after the second year;
- Compliance with any TAP requirements pursuant to the TAP Policy and under any Aide Memoire concluded between GAVI and the Country;
- Compliance with GAVI's standard terms and conditions (attached in Appendix [D]); and
- Compliance with the then-current GAVI requirements relating to financial statements and external audits, including the requirements set out for annual external audit applicable to all GAVI cash grants as set out in GAVI's grant terms and conditions.

The HSS cash support shall be subject to GAVI's performance-based funding (PBF). Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved ceiling, or programme budget if different (the initial Annual Amount), as an upfront investment. After the first year, countries will receive 80% of the ceiling, or programme budget if different, based on implementation of the grant, and additional payments will be based on performance on immunisation outcome indicators. Note that countries whose total grant budget would fall below US$3 million are exempt from this 80% rule.

Country will have the opportunity to receive payments beyond the programme budget amount, for exceptional performance on the same immunisation outcomes. The maximum programmed payment plus performance payment may be up to 150% of the country ceiling.

Given that Country's DTP3 coverage was **at or above 90%** in 2011 based on WHO/UNICEF estimates, Country will be rewarded for sustaining high coverage with:

- 20% of programme budget for maintaining DTP3 coverage at or above 90% and
- 20% of programme budget ensuring that 90% of districts have at or above 80% DTP3 coverage.

The performance payments under the performance-based funding shall be used solely for activities to be implemented in the country's health sector.

7. Programme Duration[1]: 2013 to 2017

8. Programme Budget (indicative):

Note that with PBF, annual disbursements may be more or less than this amount after the first year (see section 6 above).

	2013	2014	2015	2016	2017	Total[2]
Programme Budget (US$)	2,462,813	1,977,144	1,960,883	1,968,345	1,970,785	**10,339,970**

9. Indicative Annual Amounts (indicative):

The following disbursements are subject to the conditions set out in sections 6, 10, 11 and 12:

Programme Year	**2013**	**2014**	**Total[3]**
Annual Amount ($US)	2,462,813	1,977,144	4,439,957

10. Documents/information to be delivered prior to HSS cash disbursement (Financial clarifications):

11. Documents to be delivered for future HSS cash disbursements:

The Country shall deliver the following documents by the specified due dates as part of the conditions for approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates
Annual Progress Reports (APRs). The APRs shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well as the PBF indicators as listed in section 6 above. The APRs should also include a financial report on the use of GAVI support for HSS (which could include a joint pooled funding arrangement report, if appropriate) and use of performance payments, which have been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent.	15 May 2013 or as negotiated with Secretariat
Interim unaudited financial reports. Unless stated otherwise in the existing Aide Memoire between GAVI and the Country, the Country shall deliver interim unaudited financial reports on the HSS cash support no later than 45 days after the end of each 6-month reporting period (15 February for the period covering 1 July – 31 December and 15 August for the period covering 1 January – 30 June). Failure to submit timely reports may affect future funding.	15 February and 15 August
In order to receive a disbursement for the second approved year of the HSS grant (2014), Country shall provide GAVI with a request for disbursement, which shall include the most recent interim unaudited financial report.	As necessary

[1] This is the entire duration of the programme.
[2] This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.
[3] This is the amount approved by GAVI.

12. Other conditions: The following terms and conditions shall apply to HSS support.

Cash disbursed under HSS support may not be used to meet GAVI's requirements to co-finance vaccine purchases.

In case the Country wishes to alter the disbursement schedule over the course of the HSFP programme, this must be highlighted and justified in the APR and will be subject to GAVI approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process both in its technical process function and its support during implementation and monitoring of the HSFP programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed On behalf of the GAVI Alliance

By: Hind A. Khatib

Hind Khatib-Othman
Managing Director, Country Programmes

Date:

APPENDIX B

Type of report: Report of the Independent Review Committee
Type of support requested: Health System Strengthening (HSFP)
Application method: Common Proposal Form
Date reviewed: Geneva, 5th – 12th April 2013

Country profile/Basic data

Type of Proposal (New or resubmission)	Resubmission
Type of application (Request template/common form)	Common Proposal Form
Proposal duration	5 years: July 2013 – June 2018
FMA status	FMA field visit completed FMA report to be finalised
Budget required (US$)	US$ 10,339,368
GAVI Annual ceiling (US$)	First year: US$ 2,460,000 Next years: US$ 1,970,000 (Total: US$ 10,340,000)
National health policy strategy plan (NHPSP) duration	6 years (July 2012-June 2018)
Country multi-year plan (cMYP) duration	5 years (2013-2017)
Final NHPSP included	Yes
Current cMYP included	Yes
Population (year/source)	10,400,000 (HMIS 2011 & Census 2012) 11,271,786 (GAVI 2012)
IMR (year/source)	50/1000 (DHS 2010) 38/1000 (GAVI 2012)
DTP3 Coverage (country/UNICEF, year)	97% (WHO/UNICEF 2011)

1. History of GAVI HSS support

The country has received HSS support previously, during 2006-2009. An IRC Report indicated that critical problems arose due to delayed disbursement at the operational level because activities under HSS funds were not implemented. In this second submission, the country is to be commended for the quality and comprehensive nature of the present application.

The country's experience in the last ten years concludes that a strengthened health system will increase coverage, reduce dropout rates and increase equity of access to all priority health services, including priority MNCH services like EPI/VPD. The proposal, submitted with a strong EPI focus, is designed to strengthen the health system in an integrated manner to achieve the desired outcomes that are shared with the current health strategic plan, HSSP III.

2. Composition and functioning of the HSCC

Under the auspices of the MOH and GoR, oversight of the GAVI HSS project will be provided through various committees, including the ICC. The ICC interagency coordination committee (ICC) includes senior officials from the Ministry of Health, representatives from different funding partners (WHO, UNICEF, USAID, etc.), plus some local NGOs, including URUNANA Development Communication, Bureau de Formation Medical Agree au Rwanda (BUFMAR) and Rotary Club International.

The ICC is quoted as being quite active, and playing a significant technical and advocacy role to support the program. ICC meetings are periodically held and the meeting recommendations approved through a formal written minutes. IRC reports for NVS in 2012 also indicate that the ICC meets regularly.

The Health Sector Cluster Group (HSCG) coordinates and provides the technical and political platform during implementation. The HSCG was mandated to coordinate the development of the GAVI proposal. The Group is chaired by the Permanent Secretary of the Ministry of Health and co-chaired by a representative of partner organizations elected by her peers. HSCG meets once every three months and performs an annual review of the health programs.

The CSOs have not only participated in development of this proposal but they will also participate in implementation phase. Letters of support from three CSOs are included with the application.

The ICC meeting chaired by the Minister of Health endorsed the submission of the HSS proposal to GAVI on 30 January 2013.

3. Comprehensive Multi Year Plan (cMYP) overview

The cMYP was published by the Rwanda Biomedical Center (RBC) in July 2012 and covers 2013-2017. The cMYP Costing Tool is also provided.

The Rwanda Biomedical Center (RBC) is the MoH implementing arm and encompasses different programs of the MoH. It was created as part of the reform in the Ministry of Health and includes the former EPI, which is now called Vaccine Preventable Diseases Division (VPDD) and comprises eight technical staff.

The EPI focuses upon the integration of immunization services at fixed health centres, and a combination of several approaches to reach the unreached in health catchment's areas, especially in the hard to reach areas; this is well described in the CMYP. More than 90% of Rwandan's children are immunized at the fixed immunization sites. The cMYP provides good information about key aspects of immunization program, including management, vaccine schedules, SIAs cold chain, mortality rates, planned coverage, dropout rates, etc. Further, the cMYP highlights areas with low immunization coverage.

The proposal provides a comprehensive table of strengths and weaknesses, which highlights weaknesses relating to service delivery, vaccine supply and management, cold chain and logistics, surveillance, communication, management, capacity building and finance. Many of the specific weaknesses indicated relate to needs for HSS. The cMYP also identifies risks, which includes the inability of the country to promise continued use of HPV as scheduled.

The cMYP also identifies priorities and challenges, in particular data management, storage capacity, unreached children, and objectives, milestones, gap analysis and goals, which provides a good synergy with the content of the HSS application.

A well-articulated draft of the Third Health sector strategic plan (2012-2018) is also provided and closely reflects the goals, objectives and performance indicators on the cMYP (p. 7-8) and EPI program-specific baseline and targets, including DTP3 coverage and drop-out rates (p. 12).

4. Monitoring and Evaluation/Performance Framework

The Goal of the proposal is to strengthen the health system in order to contribute to the reduction of under-five mortality rate (to 57/1,000 live births by 2017). The M&E performance framework is built around the five strategic objectives of the project, which are summarized below:

Strategic Objective 1: To strengthen the logistics and supply chain management capacity of the national health system so as to effectively sustain optimal stock levels of essential medical commodities, including EPI/VPD commodities, at all levels of the health system. Three activities relating to storage capacity, distribution and management quality are planned and outcomes clearly defined.

Strategic Objective 2: To strengthen generation and utilization of strategic information for responsive management of health services at all levels of the health system. Two activities are planned, which relate to improving data quality and strengthening M&E capacity.

Strategic Objective 3: To improve community access to uptake of priority health services, including EPI/VPD services, at district level, so as to improve health outcomes in the populace. Five activities are planned and outcomes clearly stated.

Strategic Objective 4: To reinforce the capacity of epidemic and infectious disease surveillance (EIDS) at all levels, and extend its scope to new diseases. Two activities are planned, with outcomes that relate to responsiveness to epidemic and infectious disease surveillance

Strategic Objective 5: To enhance the capacity of health system management at district level for effective and efficient delivery of priority health services, including EPI/VPD services. Three activities are planned, centring on HR strengthening, surveillance and waste management.

The five objectives will be monitored through 2 impact, 15 outcome, and 14 output indicators.

Strategic Objectives 2, 4 and 5 are entirely dedicated to addressing core health system wide challenges undermining delivery of all priority health services (including EPI/VPD services). Strategic objectives 1 and 3 not only strongly address HSS challenges that specifically undermining delivery of EPI/VPD services, but to a large extent other priority health services as well.

Indicators are in line with objectives and covers broad range of relevant issues as described in the objectives and key activities. Baseline and yearly target information are also provided for each of the indicators. There are some indicators that need improvement. For example, indicators 1.1b and 1.2 overlap with each other; indicator 2.2 needs text revision and looks vague; there is no gender-related indicator; and there is no indicator to measure the wealth quintile-based immunization coverage.

Narrative for each activity quantifies inputs and sub divides actions further where there are multiple inputs. Additional sections of the proposal define the main beneficiaries of the HSS support, evidence base and lessons learnt, and M&E arrangements, including M&E strengthening activities to be carried out during implementation of the HSS program.

The Draft HSSP III M&E framework providing expected outputs and outcomes, along with indicators, is also presented and shows a good synergy with other documents. Targets appear realistic and achievable. An equity indicator has not been developed (although inequality and disparities in coverage are highlighted in the proposal). A drop out indicator is included, and DPT coverage is addressed within the context of % FICs and % districts with coverage of less than 80%.

5. Linkages to immunisation outcomes

There are clear linkage between immunization outcomes and the contents of this proposal. The proposal tries to address problems in the logistics and supply chain management systems, sustaining optimal stock levels of essential medical commodities, including EPI/VPD, and improve VDP surveillance. In addition, it aims to address some systemic challenges, through improving community access to uptake of priority health services, including EPI/VPD services, at district levels and enhancing the capacity of health system management at district level for effective and efficient delivery of priority health services, including EPI/VPD services.

6. Action plan for immunisation results

The overall objective of the HSSP III is to ensure universal accessibility (in geographical and financial terms) of quality health services for all Rwandans.

The proposal is almost 100% concentrated on immunization results, grouping interventions under four categories:

1. Service delivery
2. EPI surveillance
3. Procurement and health infrastructure
4. Governance and stewardship

The proposal stresses links to corresponding components of HSSP under each intervention.

Priority constraints to be address through the GAVI HSS grant fall into the following categories:

- Logistics and supply chain management, which include storage capacity constraints, temperature-monitoring issues, obsolete equipment, and weaknesses in forecasting, supervision and maintenance. Transport at central level is also identified.
- Service delivery challenges, particularly gaps in access and coverage, and the low socio-economic quintile still bear the brunt of inequities.
- Data management, resulting in compromised data quality, discrepancies between administrative coverage and survey data, and M&E deficits at sub national levels.
- Surveillance constraints, which centre primarily on financial resources.
- Gaps in community system strengthening.
- Governance and leadership challenges, relating to management skills and competencies, and absence of an NRA.

Current HSS efforts to address key gaps include supportive policies and strategic frameworks for strengthening the health system, and interventions addressing the Human Resources for Health (HRH) crises with support from Development Partners (USAID, CDC, WHO, SDC, Global Fund, CSO). The Log Frame is developed and is 100% aligned with the application, both by activity reference and by deliverable.

7. Feasibility

The country demonstrates lessons learned and evidence in the proposal, along with a clear intention to integrate immunization services into primary health care at fixed service delivery sites.

The objectives and interventions are implementable and are mostly concentrated around EPI. The description of proposed activities inspire confidence that the proposed outputs and outcomes can be delivered.

8. Soundness of the financing plan and its sustainability

Rwanda's GDP per capita is US$ 570. There is still high level of poverty in the country: over 44.9% of the population lives in poverty and 24.1 per cent in extreme poverty and is ranked 166th under the Human Development Index (HDI, 2011).

Despite commendable achievements in health insurance and financial integrity countrywide, there is need to progressively wean the health system off from the relatively high donor based health financing; donor input in health sector financing has been reported to be 49%.

Currently there are no National Health Accounts. Health financing data can be accessed through the MOH Finance and Budget Division and the MOF. The respective quality and quantity of contributions by development partners has not been compiled to date. The government contributes 16% of the total expenditure on health, while households and donors contribute 15% and 63%, respectively. An analysis of the HSSP III funding done by an international consultant shows that funding may be anywhere from a US$ 964 million deficit to almost US$ 192 million surplus over the next six years. A funding gap analysis for HSS is provided using the GAVI template. The unit costs appear to be in local currency however. Converted to US this indicates a funding gap of US$ 500,000-600,000/yr.

The MoH budget increased by 265.3 % from 2006 to 2010 (from US$ 63,141,386 to US$ 167,546,070). During the same period, the recurrent budget of the MOH increased from US$ 30,295,183 to US$ 111,877,390, while the capital development budget increased from US$ 32,846,203 to US$ 55,668,680. Available data from the MOH budget show that funds are increasingly being invested in resource development, especially infrastructure and human resources for health. This is because the health system is being increasingly strengthened. This has created stiff resource competition between capital and recurrent expenditures- as further attested by the budget of the cMYP 2013 - 2017. The heavy dependence on donor financing of the health sector creates health financing sustainability concerns. Nevertheless, the GoR is proactively supporting all sectors- including MOH- to ensure continued bolstering of the economy and progressive weaning of the country off from donor-inclined financing.

The CMYP provides a year by year EPI cost projection through 2017. A budget of $153m is estimated for routine program and a further $6m for SIA's. The CMYP also does a detailed gap analysis for 2013.

The financial plan, cost elements and line item costs are reasonable and activity linked. It is noted that there is $378,000 earmarked for CSO support, and $1.124m to support EPI staff salaries for 5 years plus $907,000 in daily subsistence allowances'. Other costs include, cold chain equipment, waste management equipment, training of health workers etc.

9. Added value

This project aims at improving service delivery to all communities regardless of geography, socio-economic status and creed. Through the community health workers (CHWs), all strata of the populace are to be reached and benefit from EPI/VPD and other priority health services. This will ensure equitable access to the all priority health services. The well-established PBF in Rwanda, the needs based design of the objectives and strategies of this proposal should ensure and insure financial efficiency throughout the GAVI HSS project. The Log Frame and the performance framework also ensure equity and efficiency while at the same time projecting effectiveness.

The program is mostly focusing on strengthening the routine programs. The capacity building of district managers and introduction of a result based management will contribute further to improve immunization as well as health system outcomes.

The involvement of CSO at community levels for social mobilization, training of CHWs at community level and strengthening integrated outreach services will certainly add values. In addition, improving information system and reducing vaccine wastage that are targeted under this proposal will also be contributing to adding values to overall current efforts.

10. Consistency across proposal documents

There is good consistency between the HSSP III and CMYP, and with the GAVI HSS proposal.

11. Recommendations

Approval

Clarifications: None

Recommendations:

To GAVI Secretariat
GAVI Secretariat is requested to work with the Govt of Rwanda to:

- Adjust indicators to include all 3 of the indicators in the GAVI guidelines. Drop-out rate is already included; DTP coverage is assessed indirectly through the quantification of districts with weak performance and % of fully immunised children. An equity indicator, such as wealth quintile indicator, does not appear to be directly included at present;

- Raise the gender issue with the Govt of Rwanda and determine if there is scope to confirm the statement of "no gender related inequities" by including provision in the performance framework to monitor and verify this;

- Define an exit strategy for donor support and its sustainability plans especially for salary payments.

- The GAVI TAP team records shows that there is need to clarify the role of ICC for country plans approval, therefore, the MoH shall submit to the GAVI Secretariat the revised ToR for the ICC that includes as a minimum, the authority to approve all plans (work plans and procurement plans) before implementation commences and to receive and review all technical, financial and audit reports.

Annex A: Country Budget Summary Template

	Jul 2013-Jun 2014	Jul 2014-Jun 2015	Jul 2015 – Jun 2016	Jul 2016-Jun 2017	Jul 2017-Jun 2018	TOTAL (US$)
	Year 1	Year 2	Year 3	Year 4	Year 5	
Grant Programme Year	2013	2014	2015	2016	2017	
Budget request from Country Proposal (US$)	2,462,813	1,977,144	1,960,883	1,968,345	1,970,785	**10,339,970**
Upper ceiling Budget approved by IRC, (US$)	2,462,813	1,977,144	1,960,883	1,968,345	1,970,785	**10,339,970**
5 year annual ceilings provided by GAVI (US$) [annual budget cannot exceed this amount]	2.46m	1.97m	1.97m	1.97m	1.97m	10.33m

APPENDIX C

GAVI's Health System Strengthening (HSS) cash support:
Performance based funding (PBF)

Performance based funding (PBF) is the default approach for all HSS cash support. As approved by the GAVI Board in November 2011, countries approved for HSS grants in 2012 and onwards will be implementing their grants with PBF. PBF was designed to create incentives for countries to improve immunisation outcomes by strengthening health systems. Improved immunisation outcomes will be rewarded by linking disbursement of funds to performance.

Under the PBF instrument, GAVI's HSS cash support will be split into two different types of payments: **a programmed payment**, based on progress in implementation and on achievement of intermediate results, and a **performance payment**, based on improvements in immunisation outcomes. The key elements of the PBF instrument are as follows and shown in Figure 1 below.

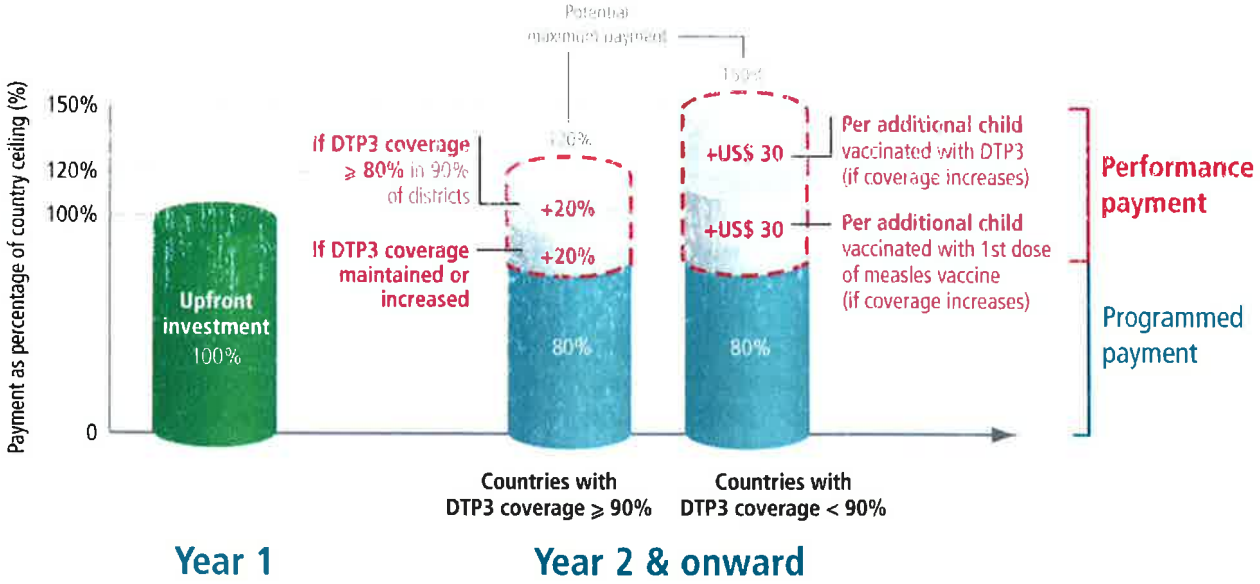
- GAVI calculates the total funding envelope for each country (referred to as country ceiling) based on the country's GNI and total population and communicates these ceilings directly to countries.
- In the first year, all countries will receive 100% of the annual country ceiling as an upfront investment. After the first year, countries will receive 80% of the country HSS ceiling (or approved budget if different) as the programmed payment if progress in implementation and achievement of intermediate results is satisfactory.[4]
- Countries may earn additional payments (above 80%) as performance payments, which may exceed the country ceiling.
- Performance payments will be as follows:
  - Countries with DTP3 coverage at or above 90% at baseline will be rewarded for sustaining high coverage with:
    - 20% of ceiling for maintaining DTP3 coverage at or above 90%, and
    - 20% of ceiling ensuring that 90% of districts have at or above 80% DTP3 coverage.[5]
  - Countries with DTP3 coverage below 90% at baseline will be rewarded for improving coverage with:
    - $30 per additional child immunised with DTP3, if DTP3 coverage increases, and
    - $30 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases.

Performance payments will be based on country reporting of results using administrative data, with WHO/UNICEF estimates and surveys used for data verification. Countries with discrepancies are encouraged to invest in strengthening data quality and routine information systems. Countries may include such investments in their HSS grant application to GAVI, as well as work with GAVI Alliance and other development partners to strengthen routine information systems and data quality.

[4] The following are exempt from this 80% rule: those countries whose total grant budget would fall at or below US$3 million when this rule is applied.

[5] If both conditions are met, the country may receive 120% of the ceiling in a given year.

Figure 1: GAVI's PBF instrument for HSS cash support



To address these concerns, the GAVI Alliance will work with countries on a country-by-country basis as part of an iterative application development process to identify data quality strengthening actions and other solutions pertaining to monitoring data that are tailored to countries' needs. This will include supporting countries to develop and institutionalise routine systems for monitoring data quality on an on-going basis, as well as a verification exercise through a health facility survey that also examines facility readiness to provide immunisation services and vaccine stock-outs. Results will be summarised in data quality report cards (as developed by WHO) and tracked over time to assess progress made in strengthening routine systems and may be supplemented by an immunisation data quality assessment (IDQA). Regular household surveys are a critical component of a comprehensive M&E plan, and are essential for PBF. WHO recommends that countries have two household surveys every five years, with one including a full birth history. Countries applying for GAVI HSS funds should ensure that their M&E plan specifies when planned surveys will be conducted that assess immunisation coverage and factors associated with non-immunisation.

While GAVI's current PBF approach is applied to HSS grants at the national level, countries may be encouraged to use performance-based funding and incentives at sub-national levels. Health sector stakeholders increasingly view PBF as an important complement to investing in inputs. It is a way to motivate communities, clients, and health workers; focus attention on measurable results; build capacity to manage and deliver health services; and, ultimately improve health outcomes. GAVI encourages such programs, particularly those linked to immunisation outcomes. An example that combines demand- and supply-side financing may include providing incentives to health workers and parents for fully immunising a child and keeping the vaccination card. However, any such programmes will also need to address concerns on data verification, management and implementation capacity, sustainability and long-term funding.

Finally, given that GAVI's PBF approach is new, learning from the first phase of countries will be applied to improve the PBF approach in the future.

GAVI Alliance Terms and Conditions

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THIS PROPOSAL

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the country for any claim or loss relating to the programmes described in this application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

USE OF COMMERCIAL BANK ACCOUNTS

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.