Appendix B-1

Lao PDR VACCINE SUPPORT

This Decision Letter sets out the Programme Terms of a Programme.

1. **Country:** Lao PDR
2. **Grant Number:** 1215-LAO-04a-X
3. **Date of Decision Letter:** 25 October 2013
4. **Date of the Partnership Framework Agreement:** 7 June 2013
5. **Programme Title:** New Vaccine Support
6. **Vaccine type:** Pentavalent
7. **Requested product presentation and formulation of vaccine:** DTP-HepB-Hib, 1 dose(s) per vial, LIQUID
8. **Programme Duration**[1]**:** 2009-2015
9. **Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement):**

	2009-2013	2014	2015	Total[2]
Programme Budget (US$)	US$5,680,657[3]	US$1,280,000	US$945,000	US$7,905,657

10. **Vaccine Introduction Grant:** Not applicable
11. **Indicative Annual Amounts (subject to the terms of the Partnership Framework Agreement):**[4]
The Annual Amount for 2014 has been amended.

Type of supplies to be purchased with GAVI funds in each year	2009-2013	2014
Number of Pentavalent vaccines doses	-	606,500
Number of AD syringes	-	641,000
Number of re-constitution syringes	-	-
Number of safety boxes	-	7,125
Annual Amounts (US$)	US$5,680,657[5]	US$1,280,000

[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 consolidated amount for all previous years.
[4] This is the amount that GAVI has approved. Please amend the indicative Annual Amounts from previous years if that changes subsequently.
[5] This is the consolidated amount for all previously approved years.

12. Procurement agency: UNICEF. The Country shall release its Co-Financing Payments each year to UNICEF.

13. Self-procurement: Not applicable

14. Co-financing obligations: Reference code: 1215-LAO-04a-X-C According to the Co-Financing Policy, the Country falls within the group Intermediate. The following table summarises the Co-Financing Payment(s) and quantity of supply that will be procured with such funds in the relevant year.

Type of supplies to be purchased with Country funds in each year	2014	2015
Number of vaccine doses	85,300	74,700
Number of AD syringes	90,100	-
Number of re-constitution syringes	-	-
Number of safety boxes	1,025	-
Value of vaccine doses (US$)	US$166,068	-
Total Co-Financing Payments (US$) (including freight)	US$180,000	US$157,500

15. Operational support for campaigns: Not applicable

16. Additional documents to be delivered for future disbursements: Annual Progress Report 2013 is due by 15 May 2014

17. Financial Clarifications: Not applicable

18. Other conditions: Not applicable

Signed by,
On behalf of the GAVI Alliance

Hind Khatib-Othman
Managing Director, Country Programmes
25 October 2013

Appendix B-2

This Decision Letter sets out the Programme Terms of a Programme.

1. **Country:** Lao PDR
2. **Grant number:** 1215-LAO-10d-Y
3. **Date of Decision Letter:** 25 October 2013
4. **Date of the Partnership Framework Agreement:** 7 June 2013.
5. **Programme Title:** Health Systems Strengthening (HSS)
6. **HSS terms:**

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

- The relevant GAVI HSFP guidelines. Please contact your CRO at rajkumar@gavialliance.org or email gavihss@gavialliance.org for the guidelines.
- The relevant GAVI HSFP application form. Please contact your CRO at rajkumar@gavialliance.org or email gavihss@gavialliance.org for the 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 funding being available;
- Submission of satisfactory Annual Progress Reports (APRs) by the 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] or as set out in the PFA); 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 IRC considered the achievement of Lao PDR to determine if the country is entitled to receive a PBF payment. It did not recommend the reward stating the coverage was not confirmed by LSIS survey data. The details are provided in Section 9 (last paragraph) of the attached IRC report.

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 **below 90%** in 2011 based on WHO/UNICEF estimates, Country 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.

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**[6]**:** 2012-2015

8. **Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement, if applicable):**
Note that with PBF, annual disbursements may be more or less than these endorsed amounts after the first year (see section 6 above).

	2012-2013	2014	2015	Total[7]
Programme Budget (US$)	US$899,324	US$600,868	US$600,026	US$2,100,218

9. **Indicative Annual Amounts (indicative) (subject to the terms of the Partnership Framework Agreement):**
The following disbursements are subject to the conditions set out in sections 6, 10, 11 and 12:

Programme Year	**2012-2013**	**2014**	**Total**[8]
Annual Amount ($US)	US$899,324	US$600,868	US$1,500,192

10. **Financial Clarifications:** The Country shall provide the following clarifications to GAVI[9]:

If the bank account information most recently provided to GAVI has changed or changes prior to disbursement, the country will need to complete a bank account information form. Please contact gavihss@gavialliance.org for the form.

[6] This is the entire duration of the programme.
[7] 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.
[8] This is the amount approved by GAVI.
[9] Failure to provide the financial clarifications requested may result in GAVI withholding further disbursements

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 2014 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

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 by,
On behalf of the GAVI Alliance

pp Alan Brooks

Hind Khatib-Othman
Managing Director, Country Programmes
25 October 2013

Appendix C

Type of report: Annual Progress Report

Country: Lao PDR

Reporting period: 2012

Date reviewed: 23 July 2013

1. Background Information

Surviving Infants (2012): 174,268 (UNPD), 173,054 (JRF)

DTP3 coverage (2012):

- JRF Official Country Estimate:79 %
- WHO/UNICEF Estimate: 79 %

Table 1. NVS and INS Support

NVS and INS support	Approval Period
DTP-Hep B	2002-2009
Hep B Mono	2006-2010
Penta	2009-2015
HPV	2013-2014
Pneumo	2013-2015
INS	2002-2004

Table 2. Cash Support

Cash support	Approval Period
ISS	2002-2012*
HSS	2010-2015

***eligibility for ISS ended in 2011 when Lao PDR it began to participate in PBF for HSS**

2. Composition and Functioning of Inter-agency Coordinating Committee (ICC) / Health Sector Coordinating Committee (HSCC)

The APR says that the ICC met four times in 2012. No CSOs participate in the ICC. The minutes of the ICC and HSCC meetings approving the APR are not included with the APR, but the signatures of the committees are included.

3. Programme and Data Management

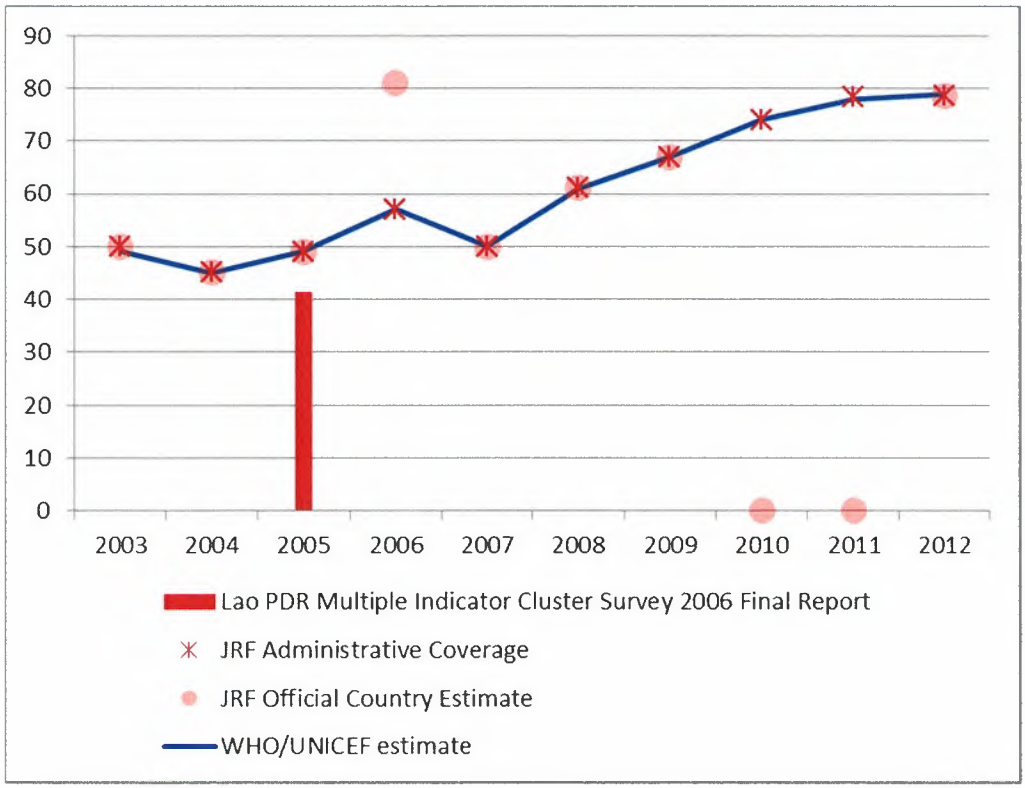
The APR shows 2,353 more DTP3 children in 2012 than in 2011.

The high points for the program in 2012 were improvements in coverage for BCG and MR, mop up MR in 25 districts, increasing outreach following recommendations of the EPI review conducted, a higher financial contribution from the GOLPDR to the program, a successful seasonal flu program, rubella introduction into the routine program, the claim of MNT elimination, and planning for JE vaccination in highly endemic areas.

Problems encountered in 2012 included: missing DTP3 and OPV3 targets, despite vaccinating more children, issues with outreach sessions because of late funding from partners and the GOLPDR and stock and cold chain management at the periphery, a stock-out of Hep B, and an increase in the DTP1-3 drop-out rate to 11 % (from 3 % in 2011).

The Lao Social Indicator Survey in 2011 showed 56 (according to the APR) or 51.5 (according to the report shown on the DHS and UNICEF MICS websites) % DTP3 coverage, much lower than administrative coverage (shown as 78 % in the APR but as 79 % in the JRF data reported by WHO), but higher than previous surveys, such as the 2005 MICS. The WHO-UNICEF estimates track the JRF administrative data. Provincial and district training has been conducted on data methods and quarterly national reviews of data are performed. Forms and mechanisms for data reporting are under review. A DQS might be conducted in 2013.

The key objectives for 2013-14 are: implement the newly adopted GVAP strategy, implement the EPI review recommendations, increase GOLPDR contributions to financing the program, introduce pneumo, improve stock management, validate the MNT elimination claim, revitalize microplanning to reach the under-served, conduct a coverage survey, and do national SIA for MR.



4. Gender and Equity Analysis

The APR says that the Lao Social Indicator Survey in 2011 showed a slight gender bias in favour of girls (55.5 to 55.4 % DTP3), but this is not considered a major disparity by the APR. No additional data collection on this topic is planned. The APR says that outreach sessions are planned to account for the seasonal timing of mothers' taking young children with them to the fields for agricultural work. Lower than targeted TT+ (44 versus 80 %) was achieved in 2012, indicating a possible gender issue. Lower coverage also looks to be related to being a member of minority groups and in households where mother's educational attainment is low.

5. Immunisation Services Support (ISS)

Lao was not eligible for an ISS reward in 2012, since it is eligible for an HSS performance based reward.

There are no ISS funds to report on.

6. New and under-utilised Vaccines Support (NVS)

The request for penta for 2014 is for vaccine to reach 16 % more children with penta 3 than in 2012. In addition, the request uses a 3 % drop-out rate and 0 % wastage for 2014 versus the 11 % drop-out rate and 5 % wastage attained in 2012. There is a large stock of penta shown available at the beginning of 2013. No change is made in the requested penta presentation, keeping the one-dose vial, rejecting the suggestion in the 2011 IRC review that consideration be given to making a change.

The quantity of penta shown as received in the APR looks to be the co-financed quantity plus the GAVI-paid quantity, rather than the GAVI-paid amount only.

The last EVM was conducted in 2010 and another is planned for 2014. The 2010 EVM report that contains an action plan is included with the APR, but not a report on progress in implementing the plan.

7. Vaccine Co-financing,Financial Sustainability and Financial Management

External partners WHO, UNICEF, and Luxembourg continue to pay for more than 90 % of traditional vaccines (GOLPDR paid for BCG vaccine in 2012) and for all injection safety supplies not covered by GAVI.

Lao is in the intermediate group for co-financing. Lao has co-financed penta since 2009 on time and is considered a good performer.

An FMA was conducted in 2009, an Aide Memoire was signed in 2011, and it has been fully implemented.

8. Injection Safety Support (INS) and Adverse Events Following Immunisation Systems

All injection safety items are paid for by external partners apart from those for co-financed GAVI-supported vaccines. There is an injection safety plan. No problems are reported.

The APR responds positively to all of the AEFI and surveillance questions except for those on sharing data with other countries. No more detail is provided.

9. Health Systems Strengthening (HSS)

The APR requests approval for an additional tranche of USD 1,198,143. It shows spending of USD 696,292 in 2012 and USD 10,693 carried into 2013. Table 9.8 shows other sources of HSS support for 2012 totalling about USD 12 million from seven external partners, notably Luxembourg for USD 4.8 million, Asian Development Bank for USD 2.0 million, and Japan for USD 1.8 million.

The APR reports all activities for 2012 completed at 100 % in three categories: capacity building, strengthening the MCH-EPI package of services, and community mobilization.

Remaining capacity challenges include: continued dependence of some HCs on district support for microplanning, quality of supervision, timely reporting on use of funds, and data recording and reporting.

No challenges are cited for the package of services or community mobilization. Active participation in community mobilization by local authorities is reported as an encouraging development. The APR notes that the program has been delayed overall by delays in receiving funds from GAVI—the APR says the delay was two years. Thus, the APR requests tranches of funds for two more years to ensure having enough on hand to implement. The APR shows planned spending for 2013 in the three categories in lump sums without detail for specific activities that reaches a total of USD 597,275. Table 9.6 on planned spending in 2014 is blank.

The APR shows eight indicators and targets that include those of the original HSS program and a new HSFP program (some original HSS indicators have been dropped and new ones have been added).

None of the eight HSS targets shown in the APR has been achieved for the full HSS program (end date 2015). Interim targets for 2012 were met for two of five items (% of women with at least one ANC and % of births attended by SBAs). Two immunization interim targets for 2012 were missed; DTP3 coverage was 78 % (v. 2012 target of 80 %) and the DTP1-3 drop-out rate was 11 % (v. 2012 target of 6 %). It is not clear what the last indicator is. It is labelled, "Equity in Immunization Coverage", but how it is measured is not specified, so it is difficult to interpret the reported 2012 achievement of 17 % versus the 2012 target of 9 %. The APR indicates that the HSS resources have been concentrated in five districts, since the APR says that in five "GAVI supported district(s)" DTP3 and measles coverage and ANC1 coverage improved substantially in 2012. The APR notes that the DTP1-3 drop-out rate is a problem and cites steps taken to address it.

The pre-assessment documents include a paper dated June 2013 recommending improvements to Lao's M&E framework. The APR makes no mention of proposing revised indicators or targets.

Under the performance based financing (PBF) initiative for HSS, Lao PDR achieved:(1) either the same or higher DTP3 coverage in 2012 compared to 2011 (the APR says administrative coverage was 78 %—the same as in 2011, but the JRF says the 2012 administrative coverage was 79 %,

higher than in 2011), (2) more DTP3 children in 2012 than 2011 (by 2,353), and (3)more measles first dose children (by 7,678). However, the Lao Social Indicator Survey shows lower DTP3 coverage (51.5 %) and lower measles coverage (55.3 %) than in 2011. Hence, no HSS PBF reward is earned in 2012.

TAP issues

- Financial statements for calendar year 2012 not provided.
- HSS Audit Report 2012 not provided yet

10. Civil Society Organization Type A/Type B (CSO)

Not applicable.

11. Risks and mitigating factors

The major risk seems to be that coverage is not as high as estimated, since the Lao Social Indicator Survey of 2011 showed lower coverage than administrative and WHO-UNICEF estimates. The indicators used for the HSS program show values below interim targets, but the program is just beginning its implementation, so there is the possibility of accelerating progress. The longer-term financial sustainability of the immunization program is at risk if the GOLPDR does not pay for traditional vaccines and basic injection safety supplies.

12. Summary of 2012 APR Review

Administrative DTP3 coverage rose in 2012, but not to the extent targeted. However, the discrepancy between the DTP3 and measles coverage found by the Lao Social Indicator Survey in 2011 and administrative coverage indicates that true coverage could be much lower than thought for the last several years and would need considerable attention.The survey-reported coverage discrepancy also means that no performance-based reward for HSFP is earned this year. The APR reports good progress in implementing health system strengthening activities in 2012. Some progress has been made on the HSS indicators shown in the APR, but the progress is slightly behind the intermediate targets shown. Lao should consider taking up the recommendations in the June 2013 paper suggesting an improved M&E framework. More information is required to approve the specific amount requested for the additional tranche of HSS funding (see clarifications asked below). In addition, a plan of activities with accompanying budget amounts for 2014 must be provided. The GOLPDR began to pay for BCG vaccine in 2012, but now should pay for all traditional vaccines and safe injection supplies. The external partners who have been paying for traditional vaccines and safe injection supplies should be asked to redirect their spending on these items to other development

needs of the immunization program. Finally, the next APR submission package should include a progress report on the EVM improvement plan.

13. IRC Review Recommendations

- **ISS**

  Not eligible.

- **NVS**

  Penta: Approve with the target adjusted in accordance of GAVI rules, subject to satisfactory clarifications detailed in Section 14

- **HSS**

  Performance based financing reward not earned since coverage data was not confirmed by the LSIS survey data.

  See TAP clarifications in Section 14.

  Approve country funding request, with the disbursement subject to satisfactory clarifications detailed in Section 14.

14. Clarification Required with Approved Funding

NVS: Clarify the penta request for doses to reach 16 % more children with penta 3 in 2014 compared to 2012, a drop-out rate of 3 % in the request versus 11 % in 2012, and 0 % wastage in the request along with the large stock of vaccine shown at the beginning of 2013.

HSS: Present a plan and budget for 2014 specifying activities (in a form that can be monitored, such as the number of microplanning trainings to be done) so that the specific amount of the next tranche can be agreed and sent.

TAP clarifications:

- Country to provide a financial statement for HSS covering the entire 2012 calendar year.
- Country to provide the 2012 HSS audit report

15. Request Re-submission of APR HSS Section (if applicable)

Not applicable.

16. Other issues

Not applicable.

GAVI ALLIANCE

Appendix D

Performance Based Funding (PBF)

PBF is the default approach for all health system strengthening (HSS) cash support. PBF is designed to create incentives for countries to improve immunisation outcomes by strengthening health systems.

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. With PBF, 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 GAVI's PBF approach are as follows:

■ GAVI calculates the total funding envelope for each country (referred to as country ceiling), based on the country's gross national income per capita 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 annual country ceiling (or approved budget if different) as the programmed payment if progress in implementation and achievement of intermediate results is satisfactory[10].

■ Countries may earn additional payments (above 80%) as performance payments, which may exceed the annual country ceiling, for a maximum potential payment of 150% of the annual ceiling.

■ Performance payments will be made 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 for ensuring that 90% of districts have at or above 80% DTP3 coverage.[11]

• Countries with DTP3 coverage below 90% at baseline will be rewarded for improving coverage with:

US$ 30 per additional child immunised with DTP3, if DTP3 coverage increases; and
US$ 30 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases.

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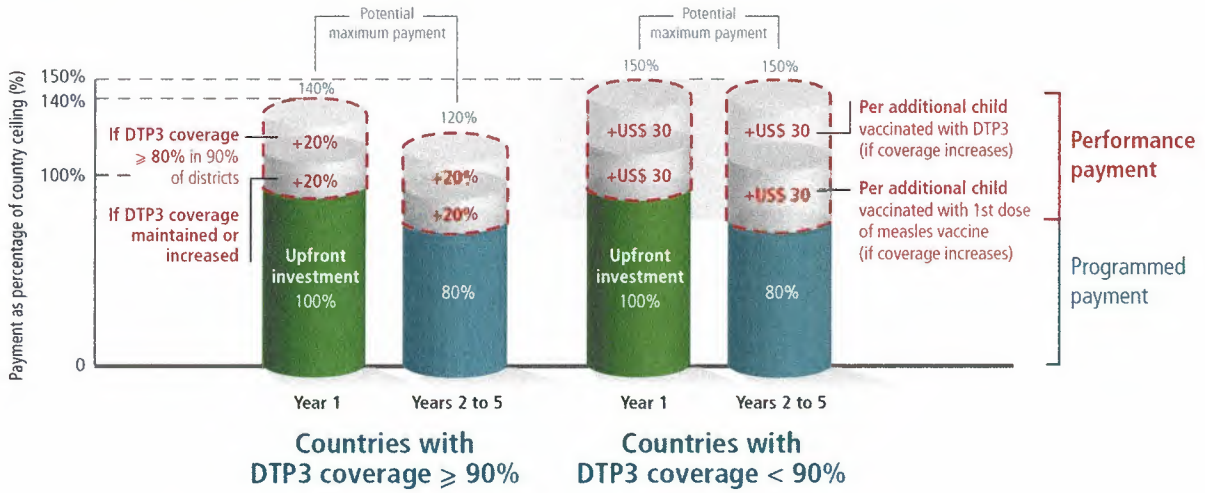
[10] The following are exempt from this 80% rule: those countries whose total grant budget would fall at or below US$3 million when this rule is applied.
[11] If both conditions are met, countries in this category may receive 120% of the ceiling in a given year.

GAVI's performance based funding approach for HSS cash support



Note: All payments are made by GAVI in accordance with GAVI's policies and procedures.
Performance payments for a given year will be made the following year, based on performance of the indicators listed and data verification.
Programmed payments for years 2-5 will be determined based on implementation and performance of the HSS grant.

Implementing GAVI's PBF for HSS cash support

Performance payments will be based on country reporting of results using country 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 and other development partners to strengthen routine information systems and data quality.

To address data quality concerns, GAVI 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.

Illustrative activities for strengthening routine information systems and improving data quality

- Strengthening routine health reporting (including surveillance and facility assessments)
- Improving vital registration (and population estimates used for denominators)
- Improving survey design, frequency, methods and content
- Improving administrative and finance data sources
- Increasing analytical capacity
- Dissemination and use of information

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. Requests for funding for these activities, including surveys, can be

made through the HSS proposal. 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; these may also be supplemented by an immunisation data quality assessment (IDQA). Regular household surveys are a critical component of a comprehensive monitoring evaluation (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, GAVI may also encourage countries 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 programmes, 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 of data verification, financial audits, management and implementation capacity, sustainability and long-term funding. There is also a need for rigorous evaluation to understand the effectiveness of such programmes in improving immunisation outcomes.

Illustrative examples of in-country (or subnational) performance based approaches linked to immunisation outcomes

- Targeted demand-side programmes such as in Udaipur, India may include payments (or in-kind incentives) to caregivers when they bring their child to be immunised.

- Vouchers for services or commodities (e.g. bednets) such as in Tanzania and Zambia may be redeemed during immunisation visits.

- Suppy-side programmes such as in Benin, Burundi, Liberia and Zambia include financial incentives for community health worker and/or health facilities when they achieve immunisation coverage targets or for each additional fully immunised child.

- Performance based contracting with civil society organisations/non-governmental organisations such as in Afghanistan, DRC and South Sudan receive a portion of their payment upon verification of immunisation targets.

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. For further information on GAVI HSS Cash Support please email gavihss@gavialliance.org