



GAVI/13/483/mk/rk

The Minister of Health
Department of Health
PO Box 807
Waigani NCD
Papua New Guinea

9 October 2013

Dear Minister,

***Papua New Guinea's 2013 application to the GAVI Alliance
for health system strengthening cash support***

I am writing in relation to Papua New Guinea'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, and subsequent approval of the clarifications you have provided, we are pleased to inform you that the GAVI Alliance has approved Papua New Guinea 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 inform you that GAVI's HSS support for your approved application will be implemented in accordance with GAVI's performance based financing (PBF) approach as per GAVI Board decision in November 2011. 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 Raj Kumar at raj कुमार@gavialliance.org if you have any questions or concerns.

Yours sincerely,

A handwritten signature in black ink, reading "Hind Khatib-Othman".

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.

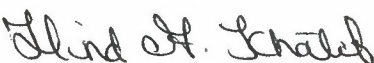
cc: The Minister of Finance
The Director of Medical Services
Director Planning Unit, MoH
The EPI Manager
WHO Country Representative
WHO HQ
UNICEF Country Representative
UNICEF Programme Division
Regional Working Group
The World Bank

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 HSS 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 HSS programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed by, 

On behalf of the GAVI Alliance
 By (Sign): **Hind Khatib-Othman**
 Name (Print): **Managing Director**
 Title: **Country Programmes**
 Date: 9 October 2013 **GAVI Alliance**

Financial and programmatic information for Health Systems Strengthening (HSS) support

This sets out the terms of a Programme.

1. Country: Papua NG
2. Grant number: 1317-PNG-10d-Y
3. Decision Letter number: 3
4. Date of the Partnership Framework Agreement: 30/08/2013
5. Programme Title: Health Systems Strengthening (HSS)
<p>6. HSS terms:</p> <p>The ultimate aim of HSS support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in:</p> <ul style="list-style-type: none"> • The GAVI HSFP guidelines • The GAVI HSFP application form • Country's approved grant proposal and any responses to the HSS IRC's request for clarifications. <p>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. PNG falls in this category, therefore, the programme budget will be supported 100% by GAVI in addition to the PBF.</p> <p>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.</p> <p>Given that Country's DTP3 coverage was below 90% in 2011 based on WHO/UNICEF estimates, Country will be rewarded for improving coverage with:</p> <ul style="list-style-type: none"> • \$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. <p>The performance payments under the performance-based funding shall be used solely for activities to be implemented in the country's health sector.</p>

7. Programme Duration¹: 2013 to 2017						
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 this amount after the first year (see section 6 above).						
	2013	2014	2015	2016	2017	Total ²
Programme Budget (US\$)	565,747	538,107	659,888	627,648	681,533	3,072,923
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	2013	2014	Total³			
Annual Amount (\$US)	565,747	538,107	1,103,854			
10. Documents/information to be delivered prior to HSS cash disbursement (Financial clarifications) :						
<ul style="list-style-type: none"> - Acceptance of the draft Financial Management Assessment (FMA) report (submitted to the country in August 2013 and awaiting the official acceptance letter for the Ministry of Health); - Approval and signature of the Aide Memoire between GAVI and the Government (draft Aide Memoire provided to the country in August 2013 and awaiting approval of the Government) 						
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	

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.

Type of report: Report of the Independent Review Committee

Country name:	Papua New Guinea
Type of report:	HSS
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/ resubmission)	New
Type of application (request template/common form)	Common Proposal Form
Proposal duration	5 years (July 2013 - June 2018)
Budget required (US\$)	3,072,923
GAVI Annual ceiling (US\$)	0.6 M pa (total 3 M US\$)
National health policy strategy plan (NHPSP) duration	2011-2020
Country multi-year plan (cMYP) duration	2011-2015
Final NHPSP included	Yes (Proposal attachment 1)
Current cMYP included	Yes (Proposal attachment 7)
Population (year/source)	Ca 7 M (World Bank, 2012)
IMR (year/source)	46 (UN Inter-agency group report on child mortality estimation, 2011)
DTP3 Coverage (country/UNICEF, year)	- 61% (JRF Official Country Estimate, 2011) - 61% (WHO/UNICEF Estimate) NB: WHO pre-assessment report states 71% (2004 data)

1. Composition and functioning of the HSCC

It is stated in the HSS proposal that the ICC covers the functions of an HSCC. The ICC discussed the GAVI HSS proposal at its November 2012 meeting; endorsement signatures were provided in February 2013, including from individuals not listed as present at the November 2012 ICC, e.g. the representatives of JICA and the Burnett Institute. No other ICC minutes have been made available.

The 13th November 2012 Child Health Advisory Committee (CHAC) meeting also endorsed the application for GAVI HSS support. The CHAC Minute signatures do not indicate any CSO representation. However, the HSS proposal describes a CHAC meeting held on 12th November, with representation from an NGO (eg. Susu Mamas).

The minutes for the CHAC and ICC meetings overlap considerably: both provide brief information on a measles SIA, challenges involved in TT 2nd round delivery to all provinces (logistics and funding issues), and a Hep B sero survey. One major difference is the mention in the CHAC minutes of the significant role played in PNG by private health providers (the cMYP 2011-2015 estimates that faith-based organisations provide 80% of health services in rural

areas), the need to ensure greater harmonisation of immunisation scheduling, management of human resources and tighter M&E integration. There is insufficient documentation in ICC and CHAC Minutes provided as to the role of CSOs in the proposed GAVI-funded HSS intervention.

The ICC and CHAC minutes also indicate considerable membership overlap. Clarity would be useful as to the relative mandates of the two committees, their core functions, etc. In addition, information as to when the full membership of both discussed the GAVI HSS proposal would be appropriate. This is pertinent given that the ICC minutes mention circulation of the draft at the November 2012 meeting, followed by endorsement.

2. Comprehensive Multi Year Plan (cMYP) overview

The cMYP covers 2011-2015; it was developed before the National Health Plan (NHP) 2010-2020, which draws upon its immunisation, IMCI and MNCH focus. There is coherence between the overarching aims of the cMYP and the NHP in terms of the focus on 'getting back to basics', to support the rural and urban poor to have adequate health services. The cMYP provides a clear overview of immunisation achievements and future challenges, in a context of weak health systems and significant human resource shortfalls. The cMYP also describes the enduring challenges of topography and terrain throughout PNG and the implications for delivery of PHC and for health outcomes. It does not provide detail as to specific provincial challenges.

The cMYP gives information on the need to support health outreach activities and their central importance to delivery of immunisation services (currently outreach services are estimated to provide 30% of all immunisation services). There is nonetheless mention of outreach services not showing a major contribution to improving the overall somewhat static immunisation situation.

The cMYP briefly considers integration of immunisation with other Primary Health Care interventions, noting this would require adequate service delivery planning and improved quality of service at community levels.

Table 3 in the cMYP sets out trends for 2006-8 for a number of key immunisation indicators; improvements are presented for cold chain equipment and inventory and focus on AEFI. There are considerable fluctuations in reported national Penta coverage (75%/60/60); the percentage of districts with Penta coverage above 80% is reported as nil/21/12. No explanation is given for the fluctuations. Targets during the lifetime of the cMYP are for national Penta coverage to be above 90% and for 90% of districts to achieve coverage above 80%.

Section 4 of the cMYP addresses costing and financing. As will be shown in section 7 of this report, 50.84% of the entire GAVI support budget has been allocated to fuel for outreach teams. The cMYP states that 'transportation equipment' is primarily dedicated to supporting outreach teams and that 'Government is fully committed to paying the maintenance and running cost of all the vehicles and boats.' Fuel is not specified as a recurrent item. Table 17 provides a financial gap analysis 2011-2015 for transportation equipment of between US\$ 80,000-85,000 per annum. The cMYP does not address how such shortfalls might be addressed. In this context, the Proposal indicates that GAVI funds will be used to finance 50% of all transport costs (including fuel), while the remainder will be financed through NDoH routine funds.

The cMYP discusses the rationale for the Provincial Health Authority (PHA) reform; this is described as an initiative led by the NDoH Health Sector Reform Unit to combine provincial health management, empowering provincial managers to improve service delivery. Within the PHA reform, the development of a Single Financing Framework at provincial level aims to offer provincial health authorities holistic and predictable management of financing sources and mechanisms. It is not clear how far the PHA has been implemented to date.

3. Monitoring and Evaluation/Performance Framework

There is relative coherence between the National M&E Strategic Plan 2011-2020 (part of the NHP 2011-2020) and the proposal Performance Framework. The national M&E Plan focuses on

an integrated approach to health systems strengthening, while the Proposal Performance Framework addresses health systems through outreach and supervision.

There is consideration of data collection and data flows from facility/district and province levels (defined as peripheral) to the national level, and brief attention to how GAVI support is intended to strengthen M&E capacity. There is no discussion of how data collected will be used in an iterative process to support any necessary changes to activities that are funded by GAVI HSS support.

The national M&E Plan has a focus on process and on health systems with a view to the comprehensive monitoring of health systems elements, such as resources (inputs), quality of service, service statistics, service coverage, client/patient outcomes (behaviour change/ morbidity) and impact. The Plan includes a Performance Assessment Framework (PAF), with a set of 29 high-level core indicators to track progress in the implementation of the NHP 2011-2020. PAF indicators directly relevant to Proposal activities to improve immunisation outcomes are numbers 8 (outreach clinics), 9a (measles immunisation) and 20 (supervision). There is variation in baseline and targets for all three Performance Framework indicators, with consistently slightly lower targets across the five-year intervention compared to PAF targets.

The PAF includes indicator 9b (without details of baseline, etc): *Proportion (%) of one year old children who are vaccinated with 3 doses of DPT-HepB-Hib (pentavalent vaccine)*. This does not feature in the Performance Framework.

None of the three GAVI Strategic Goal II indicators have been addressed in the Proposal or included in the Performance Framework.

The Proposal suggests that the sole exception to the HSS intervention's use of the existing NHIS should be the immunisation data collected on Outreach Forms. The HSS Proposal and the Outreach Guidelines (proposal attachment 18) indicate quarterly visits; this frequency may support collection of community and household-level data based on potentially strong recall. Therefore, the inclusion of such data is recommended by the IRC.

4. Linkages to immunisation outcomes

The Proposal title is: 'Intensified integrated EPI/MNCH outreach in eight selected low performing provinces of Papua New Guinea'. The over-arching objective of the proposed HSS intervention is to provide an EPI/MNCH integrated package of services in 134 health centres (ca 20% of the national total) in 14 districts situated in eight provinces (however, the proposal actually lists nine provinces and 15 districts to be included in the package of services, while the Performance Framework lists nine provinces and 14 districts). Six of the nine provinces listed in the proposal are stated to receive AusAid support in EPI.

Criteria for selection of the intervention areas are described as based on latest epidemiological data, coverage data (DTP-3 coverage and unvaccinated children), relative poverty, performance factors, difficult environment, weak managerial and administrative processes, human resource constraints and other unspecified needs. Choice of provinces has been informed by findings of the 2012 measles SIA and other outreach work.

The specific Proposal objectives are to be delivered by outreach health teams working in rural areas; activities are planned to be quarterly and to be conducted by a two-person team.

Five objectives are listed in the Proposal, of which the first is directly linked to immunisation outcomes:

- (i) To provide immunisation to women and children;
- (ii) To provide antenatal check-up to pregnant mothers and post natal care;
- (iii) To provide family planning services and referral for tubal ligation or vasectomy;
- (iv) To monitor the weight and growth of children and treatment of illness, if any;
- (v) To provide health education to the community including water supply, sanitation and hygiene.

A sixth objective is mentioned in the Budget and Workplan and also in the Logframe: to conduct disease control activities and treatment of minor illnesses as required.

None of the 5/6 objectives explicitly addresses health systems strengthening.

The Proposal discusses findings of the July 2012 regional GAVI workshop, which highlighted health systems management, funding gap and human resource challenges that have an impact on immunisation service delivery (and wider PHC). Section 2.2 (Key Health System Constraints) provides a compelling overview of the many, interlinked challenges facing health service delivery.

The Proposal provides an overview of existing HSS interventions. There is mention of the Bougainville Direct Health Facility Finance pilot and how its implementation may provide useful lessons – this is why Bougainville is included as one of the 8/9 provinces to receive support.

5. Action plan for immunisation results

On balance, the Proposal narrative provides a cogent argument for its focus on outreach activities as the optimal action plan for improvements in immunisation and related health outcomes. Section 3.1 provides an overview of how the GAVI-funded HSS objectives will contribute to achievement of improved immunisation and wider MNCH health outcomes. The 5/6 objectives are linked to the NHP Key Result Areas (KRA) 1, 4, 5 and 6 (service delivery and health outcomes) and rather more indirectly to KRA-2: *Strengthen Partnership and Co-ordination with Stakeholders* and KRA-3: *Strengthen Health System*.

A relative weakness of the proposal is that it does not discuss in much detail how the GAVI funding might specifically support HSS improvements that are likely to have a direct bearing on immunisation outcomes, e.g. inputs to rectify the acknowledged weaknesses and entrenched health service management challenges of public and non-state provider health service delivery at provincial, district and health facility levels. While the Proposal provides a rationale for dedicating much of the GAVI funding to support outreach teams, it does not discuss what might happen once that funding ends in terms of sustainability of any health systems strengthening outcomes.

CSO participation in Proposal development and implementation: the Proposal (Part C) states that 'All key stakeholders were consulted both in informal meetings and subsequently formally through the...ICC and the...CHAC (which is composed of paediatricians, Public Health Medical School staffs, nutritionist, and partners in public and private sector)'. Further information on the process would be useful, given the apparent key role to be played by non-state providers in service delivery. There is no budget breakdown to indicate the proportion of funds that will go to the public sector and to non-state providers and no discussion of the composition of outreach teams (will supervision teams be drawn solely from the public sector?).

Gender and equity: attachment 12 (Guidelines for Outreach Patrols) vividly demonstrates the scale of the challenge facing PNG in terms of equitable access to immunisation services: the topography and sparse road systems of PNG are stated to allow only 20-30% of the population to use static health centre services, either because they live sufficiently close to a facility or have access by road. Upwards of 85% of the population lives in rural areas.

Proposal section 3.3 does not adequately address gender and equity issues; there is no disaggregation of individual province or district barriers to immunisation access (or indeed access to related MNCH services, given the scope of the Proposal) and there is no consideration of how the outreach and supervision teams might seek to collect data on such matters. The Proposal states that 'providing foot patrols and mobile clinics to villages will ensure that an additional 70-80% of population is attended' (from which baseline is not specified); however, the cMYP indicates that 30% of all immunisation services are currently provided through outreach. There is no consideration in the Proposal of community/demand-side contributions, e.g. in terms of providing inputs regarding quality of care.

The 2011 APR noted that while there are no legal barriers to equal access, the extent of any gender inequalities is not currently known. The 2011 APR further stated that the National EPI unit had begun discussion with the National HMIS to collect sex-disaggregated data for immunisation services. Existing data formats are to be reviewed and changes made to allow for collection of sex-disaggregated data. Such developments are not reflected in the Proposal.

Consideration should be given to the inclusion of an indicator to measure reduction in a proportion of the 14/15 supported districts with DTP3 coverage under 80%.

6. Feasibility

The Proposal sets out overall a feasible case for GAVI support. It addresses previously identified HSS challenges that hinder access to immunisation services.

The Proposal is strong in its delineation of national health strategies and the imperative need to strengthen action on MDGs 4, 5 and 6. The Proposal, the cMYP and the NHP, as well as documents supporting the proposal, all present frank discussion of the many health systems challenges facing PNG. The Proposal states its intention to use the GAVI support to improve immunisation and related health outcomes, in a context of considerable change to management of health systems through the PHA devolution to provincial level.

One feasibility issue is that there is no budget line for training of either outreach or supervisory teams; another is the absence of any management objective. Outreach workers have been in the frontline of immunisation service delivery; the fluctuations in coverage described in the cMYP cannot be entirely due to challenges of terrain and distance, but must indicate shortfalls in training, HRH, etc. The Proposal describes HSS activities funded by GFATM and AusAid, but does not specify how these will harmonise with GAVI-funded activities and how these might directly enhance outreach service delivery, M&E and overall management.

7. Soundness of the financing plan and its sustainability

Part B (HSS external funding) of the Common Form Application Supplement has not been provided. As such, it is difficult to have a detailed overview of other partners' budget allocations and how GAVI HSS funding will harmonise with other sources of finance. The Proposal indicates that there is a 35% funding gap for the whole National Health Plan. Allocations to rural health services (the focus of the Proposal) are 34% of the total expenditure requirement. Further information on how much of the 34% allocation is funded for 2011-2020 (or a shorter period) is not provided in the Proposal. However, the Proposal states that the GAVI support represents 50% of the funds required to implement the planned activities and that the remainder will be covered by the NDoH through provincial and district financial flows.

As is noted in the TAP pre-screen, the budget (totalling US\$ 3.072 million) is structured by four activity categories/budget lines; it is not sufficiently broken down by each of the 5/6 objectives, Service Delivery Area (SDA) or per activity. The categories are:

- 69% of the entire 5-year budget (US\$ 2.1 million) is allocated to fuel (under 'overheads' for outreach teams and under 'M&E' for supervision); this works out at 50.84% over the 5 years for the outreach teams and the remainder for provincial and district supervisory visits;
- 22% of the total budget (US\$ 690,000) is allocated to per diems (defined as 'HR' for outreach teams and 'M&E' for supervision), of which 15.47% is for outreach teams;
- Allocations to outreach teams constitute 66.31% of the entire 5-year budget, circa US\$ 2.05 million;
- Allocations for all supervisory activities represent 24.69% of the total budget, circa US\$ 750,000; and
- The remaining 9% is divided between cold chain running costs and spare parts (6%, US\$ 190,000) and unspecified 'advocacy and communication' activities.

The cMYP mentions that only 3% of roads are paved and 'many villages' can only be reached on foot. So the allocation for fuel needs unpacking – what proportion is for road vehicles, for planes and/or boats? In addition, there is no breakdown of fuel costs per province and district

(e.g. 1 of the 8/9 provinces, Bougainville, is an island and certain of the other provinces and districts may be particularly inaccessible, requiring air transport for the outreach teams and supervisory visits).

There is no discussion in the proposal documents of the relative percentages of the budget for outreach (fuel plus per diems) that will be allocated to public health workers and non-state providers. In addition, there is no breakdown of relative budget allocations for supervisory visits to be made by public vis-à-vis non-state health workers. The Proposal emphasises that both categories of provider are to be involved in service delivery.

Procurement arrangements for fuel and cold chain spare parts are not specified.

There is no allocation in the budget for reporting (is this subsumed under 'M&E' and/or under advocacy and communication?), considering lessons learned during the five years or for exit planning and post-funding sustainability. There is no allocation for management of the intervention at any level – national, provincial, district or individual health centre, despite the proposed devolution of responsibilities and financial management to provincial level through the PHA reform.

There are a number of additional outstanding financial management issues as identified by the TAP team; these are addressed in the request for clarifications.

8. Added value

The Proposal describes how the GAVI HSS funding will support further application and expansion of the outreach model of health service delivery. The work of the outreach teams has been an integral part of health service delivery for at least five years (and presumably far longer), judging from the 2010 completion reports for the health SWAp. Given the health facility access challenges faced by a majority of the population, strengthening (and crucially, sustainability) of such interventions will likely add value to health service delivery and immunisation/MNCH outcomes. Ideally further information could be provided on the synergies with the other major HSS support interventions, so as to have a detailed overview of where points of harmonisation and added value for the GAVI supported activities are intended to occur.

9. Consistency across proposal documents

There is inconsistency across proposal documents with regard to the correct number of provinces and districts to receive outreach services and the number of objectives and integrated service packages (five or six) to be addressed. These are core aspects of the Proposal and should be coherent. In addition, there is a degree of inconsistency in proposal documentation with regard to discussion of civil society, ICC and CHAC inputs to developing the Proposal; here too, further information is required.

An element of inconsistency across the Proposal and supporting documents relates to implementation responsibility and management structures. The Proposal states the following: 'The main implementers of this proposal will be the Health Centres (Government and FBOs represented by the Christian Health Services) under the supervision of Provincial and District Health Departments with support from stakeholders such as AusAid, Christian Health Services, WHO, UNICEF and INGOs (Save the Children, World Vision, CARE. etc.)'. The Proposal also refers to AusAid provincial EPI Support Officers (6) playing a role in linking existing 'mechanisms' with GAVI support.

The Log Frame defines implementers for all five objectives as: Lead Implementer: NDoH. At Central level: 1) National Department of Health (EPI unit, Maternal Health unit), 2) Department of Planning and Finance (DPF); At Provincial and District level: 3) Provincial Health Officer (PHO) and District Health Officer (DHO); At Health Centre level: 4) In charge of the Health Centre 5) Patrol/Outreach Teams. The Performance Framework lists the NDOH as one of the two lead implementers, the other being the Christian Health Services of PNG.

The logframe lists both 6 and 5 objectives but describes activities for 5. There are minor inconsistencies in numbering of logframe impact indicators against those in the Performance Framework.

The Proposal and supporting documents should be reviewed so as to ensure consistency of content and focus.

10. Recommendations

Recommendations: Approval with clarifications (Level 1)

Clarifications: (Please see Annex B for more details.)

1. Please clarify the role of the Church Health Services (Church Medical Services) and any other CSOs in the management and implementation of the HSS activities and in the allocation and control of funds for fuel and per diems.
2. Please review the following M&E issues:
 - Inclusion of the 3 GAVI strategic indicators (Drop-out rate, DTP3 coverage and equity in immunisation coverage) in the Log Frame and Performance Framework. Baseline and annual targets should be clearly stated for each indicator.
 - Inclusion of other indicators specific to the achievement of objectives under this HSS support. Such indicators could include numbers/duration of outreach and supervisory visits to the 134 health facilities targeted in the 8/9 districts and availability (%) of functional cold chain equipment for vaccine storage. Baseline and annual targets should be clearly stated for each indicator.
 - Please include indicator 9b from the Monitoring and Evaluation Strategic Plan of the NHP 2011-2020: *Proportion (%) of one year old children who are vaccinated with 3 doses of DTP-HepB-Hib (pentavalent vaccine)*, including baseline and annual targets.
3. Please address the pending TAP issues.

Annex A: Country Budget Summary Template

Table 1. Papua New Guinea Budget Summary Table

Timeframe	Jul 2013- Jun 2014	Jul 2014- Jun 2015	Jul 2015- Jun 2016	Jul 2016- Jun 2017	Jul 2017- Jun 2018	TOTAL (US\$)
Year	Year 1	Year 2	Year 3	Year 4	Year 5	
Grant Programme Year	2013	2014	2015	2016	2017	
Budget request from Country Proposal (US\$)	565,747	538,107	659,888	627,648	681,533	3,072,923
Upper ceiling of Budget approved by IRC (US\$)	565,747	538,107	659,888	627,648	681,533	3,072,923
5 year annual ceilings provided by GAVI (US\$) [annual budget cannot exceed this amount]	0.6M	0.6M	0.6M	0.6M	0.6M	3,000,000

Annex B: IRC HSFP COUNTRY RESPONSE TEMPLATE FOR CLARIFICATION OR RESUBMISSION

IRC Recommendation (select one):
Clarification/Resubmission is received

Please complete after

- Level I Clarification
 Level II Clarification
 Resubmission

Final IRC Recommendation	
Date	

Clarification Questions/ Resubmission Issues Identified by GAVI's Independent Review Committee

Question/Issue 1 :	
Please clarify the role of the Church Health Services (Church Medical Services) and any other CSOs in the management and implementation of the HSS activities and in the allocation and control of funds for fuel and per diems.	
Supporting Documentation requested: <i>(IRC: Please list suggested supporting documentation to accompany country response)</i>	
Minutes of meetings, CSO work plans	
Applicant's Response - Issue 1:	Date: dd- MM-yy
Response:	
Supporting Documentation from the applicant relevant to the response: <i>(Applicant: Please list any supporting documentation that was provided to accompany country response)</i>	
IRC Comments and/or request for further clarifications – Issue 1 or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)	Date: dd- MM-yy
Response:	

Question/Issue 2 :
The IRC requests that the Secretariat works closely with the country to revise the original Performance Framework selected, including providing baselines, targets and denominators. Please review the following M&E issues in addition: <ul style="list-style-type: none"> • Inclusion of the 3 GAVI strategic indicators (Drop out rate, DTP3 coverage and equity in immunisation coverage) in the Log Frame and Performance Framework. Baseline and annual targets should be clearly stated for each indicator. • Inclusion of other indicators specific to the achievement of objectives under this HSS support. Such indicators could include numbers/duration of outreach and supervisory visits to the 134 health facilities targeted in the 8/9 districts and availability (%) of functional cold chain equipment for vaccine storage. Baseline and annual targets should be clearly stated for each indicator. • Please include indicator 9b from the Monitoring and Evaluation Strategic Plan of the NHP 2011-2020: <i>Proportion (%) of one year old children who are vaccinated with 3 doses of DTP-HepB-Hib (pentavalent vaccine)</i>, including baseline and annual targets.
Supporting Documentation requested: <i>(IRC: Please list suggested supporting documentation to accompany country response)</i>
A log frame and performance framework to be provided reflecting these changes.

Applicant's Response - Issue 2:	Date: dd- MM-yy
Response:	
Supporting Documentation from the applicant relevant to the response: <i>(Applicant: Please list any supporting documentation that was provided to accompany country response)</i>	
IRC Comments and/or request for further clarifications – Issue 2 or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)	Date: dd- MM-yy
Response:	
Question/Issue 3 :	
Please address the pending TAP issues.	
Supporting Documentation requested: <i>(IRC: Please list suggested supporting documentation to accompany country response)</i>	
Documentation as listed in the TAP recommendations subsequent to the country visit (March 2013) relating to:	
<ul style="list-style-type: none"> • Planning and budgeting • Governance and Coordination • Budget Execution/Fund Flows • Procurement • Accounting, Recording and Financial reporting • Internal control, internal and External Audit 	
Applicant's Response - Issue 3:	Date: dd- MM-yy
Response:	
Supporting Documentation from the applicant relevant to the response: <i>(Applicant: Please list any supporting documentation that was provided to accompany country response)</i>	
IRC Comments and/or request for further clarifications – Issue 3 or without conditions or matters the IRC wish to draw to the attention of the Secretariat to consider during grant processing) or there are further clarifications/adjustments requested)	Date: dd- MM-yy
Response:	

Recommendations Identified by GAVI's Independent Review Committee to GAVI Secretariat

Recommendation 1: GAVI Secretariat to better understand how the NDoH intends to address its funding gap specific to transport, and how it will ensure funds are available for the other 50% of fuel costs throughout the five years of GAVI HSS support, and the total fuel costs subsequent to the period of GAVI support.

Recommendation 2: The consistency across documents is improved, as discussed in section 9 above.

Recommendation 3: The IRC requests that the Secretariat works closely with the country to revise the original Performance Framework selected, including providing baselines, targets and denominators.

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 satisfactory⁴.

- 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.⁵

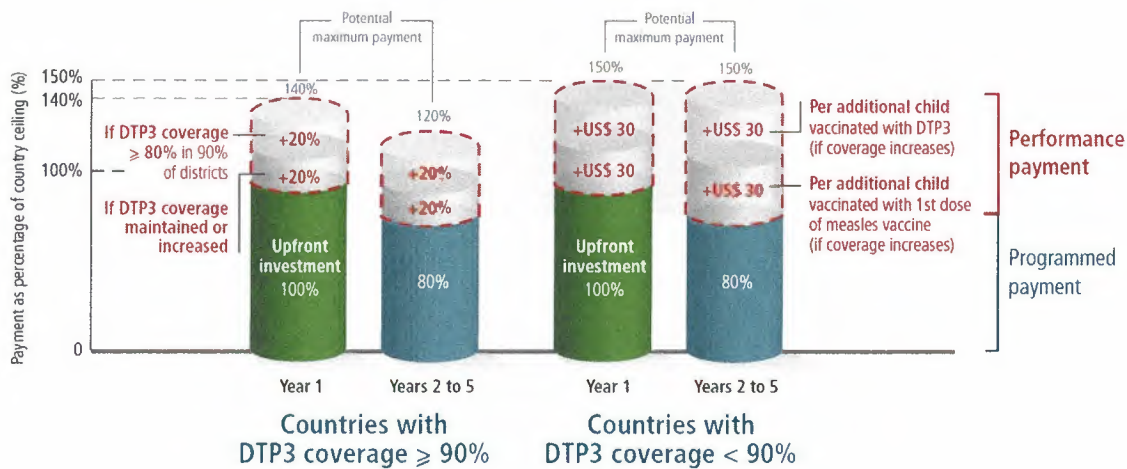
- Countries with DTP3 coverage below 90% at baseline will be rewarded for improving coverage with:

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.

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, 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.
- Supply-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