

The Health Systems Funding Platform—A Primer

INTRODUCTION

In September 2009, the High Level Task Force on Innovative International Financing for Health Systems recommended the creation of a platform to coordinate aid to health systems. The Health Systems Funding Platform (“the Platform”) is now being developed by the three largest multilateral funders of health systems strengthening (HSS)—the GAVI Alliance (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), and the World Bank (WB)—and facilitated by the World Health Organization (WHO), in consultation with developing countries and other key stakeholders.

This Primer provides an overview of the Platform for policymakers, advocates, and other global health stakeholders who want to learn about the Platform’s design, catch up on latest developments in its implementation, and understand unresolved issues that the Platform faces. Section 1 introduces the Platform’s objectives, principles, and operational framework. Section 2 describes the current status of the Platform’s implementation. Finally, Section 3 discusses open issues related to the Platform as it is currently conceived.

SECTION 1: PLATFORM OBJECTIVES AND OPERATIONAL FRAMEWORK

The Platform aims to strengthen developing countries’ health systems, with the objective of accelerating progress towards the health-related Millennium Development Goals (MDGs) 4–6.¹ In line with the principles of the Paris Declaration on Aid Effectiveness,² the Accra Agenda,³ and the International Health Partnership (IHP+), the Platform is intended “to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies.”⁴ More specifically, the Platform is designed to achieve the following goals:

- Improve harmonization of application procedures, financial management, and performance monitoring to reduce transaction costs for countries and donors;
- Better align international aid with countries’ priorities and planning, review, and budget cycles; and
- Increase predictability of funding over the course of a country’s planning cycle.

Platform partners also aim to mobilize additional HSS funding that can be channeled through the Platform.⁵

Operational framework and approach—how will the Platform function?

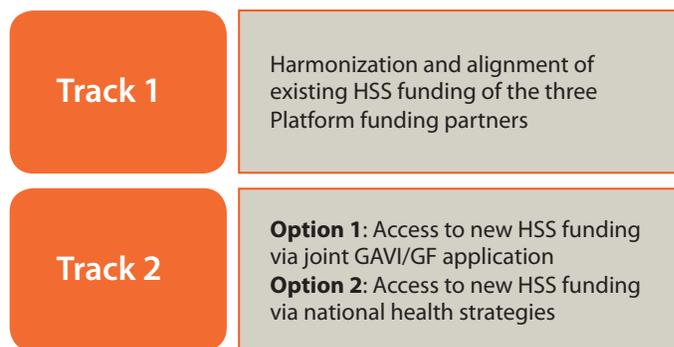
The Platform is not a new global fund for health systems, nor does it involve pooling of HSS funding at the global level. Instead, its role is to streamline HSS financing contributed by existing funding organizations. Box 1 on page 2 shows how the three Platform funding partners (GAVI, the GF, and the WB) currently support HSS and how much funding they have allocated to HSS. However, the Platform partners do not share the same definition of HSS, making it difficult to compare their HSS expenditures.⁶ While the Platform’s institutional framework is designed around GAVI, the GF, and the WB, the Platform “is open to all development partners, both at the global and country levels.”⁷ This includes those bilateral development agencies that are significant funders of HSS (e.g., the United States Agency for International Development [USAID] and the United Kingdom Department for International Development [DFID]).

The Platform aims to streamline HSS funding flows through implementation of three key principles at country level:

- One monitoring and evaluation (M&E) framework;
- One fiduciary framework that includes financial management and procurement; and
- One national health strategy that is jointly assessed, using the Joint Assessment of National Strategies (JANS) tool.

The Platform partners have developed a two-track approach to implement these three principles taking varying country realities into account (Figure 1).

Figure 1: The Platform’s ‘Two-Track’ approach



HOW DO THE THREE PLATFORM FUNDING PARTNERS SUPPORT HSS?

GAVI: All 56 GAVI eligible countries can apply for “HSS support” to improve immunization outcomes. GAVI approves HSS proposals on a rolling basis (i.e., throughout the year). In addition to HSS support, GAVI’s Incentives for Routine Immunisation Strengthening (IRIS) channel, which replaced GAVI’s Immunisation Services Support (ISS) in 2011, provides results-based funding to help countries with routine vaccination coverage rates lower than 70% to cross this threshold (currently 14 countries). GAVI’s HSS support, but not its IRIS support, is now being provided as part of the Platform. GAVI has decided that the maximum share of these cash-based programs—as opposed to vaccine programs—over the next three years should be within the range of 15–25% of GAVI’s total program expenditures. For its HSS grants, GAVI uses a resource allocation method whereby the maximum amount of funding per country is based on a country’s population and weighted against a graded gross national income scale. As of November 2010, GAVI had committed \$568.1 million to HSS, and \$393.2 million to ISS.

Global Fund: Low-income and middle-income countries can access GF support through funding “rounds” (typically once a year). There are two basic ways for countries to access HSS funds from the GF to improve outcomes related to HIV/AIDS,

TB, and malaria. Countries can integrate HSS funding requests into a disease-specific funding request (whether it is a regular disease proposal or a National Strategy Application). From Round 11 onwards, countries will also be able (again) to submit stand-alone proposals for cross-cutting HSS activities (i.e., activities that contribute to health outcomes across two or three diseases).⁸ The HSS funding accessed via cross-cutting proposals will be coordinated under the Platform (in addition to a few existing HSS funds that were requested through a disease proposal). About 37% of the GF’s portfolio was dedicated to HSS between Rounds 1–9 (6% to cross-cutting HSS, 31% embedded in disease proposals).

World Bank: In contrast to GAVI and the GF, the WB provides mostly credits, not grants, to countries. The International Bank for Reconstruction and Development (IBRD) gives low-end commercial rate loans to middle-income countries, and the International Development Association (IDA) provides interest-free credits to countries with a per capita income in 2009 of less than \$1,165. According to WB figures, almost half of the WB’s financing for health, nutrition, and population (HNP) was allocated to HSS in 2009 (\$1.4 billion of a total \$3.1 billion).⁹

Track 1: Harmonization and alignment of existing HSS funding

Track 1 aims to coordinate *existing* HSS financing and programming in countries where the GF, GAVI, and the WB have made substantial HSS funding commitments that extend into 2012. Work has started in several countries (e.g., Benin, Cambodia, Democratic Republic of the Congo [DRC]), where partners are currently focusing on the harmonization and alignment of financial management procedures, procurement systems, and M&E and performance frameworks. An important vehicle for coordinating both existing and new HSS funds is *Joint Financing Agreements* (JFAs), which commit donors to one single audit and report (as opposed to multiple audits and reports), and which are aligned with countries’ budget and review cycles. JFAs may—but do not have to—include the pooling of funds at the country level. GAVI, the GF, and the WB are all able to pool their funding, and countries can request the pooling of contributions from the Platform funding partners (and other donors) under the Platform. However, JFAs can be signed by pooling and non-pooling donors, as has been recently the case in Nepal (see Section 2). Both pooling and non-pooling donors can then work through one harmonized financial management system.

Track 2: Access to new HSS funding

The two options under Track 2 are aimed at enabling countries to access *new* HSS funding from the Platform funding partners in a more efficient and coordinated manner. Countries will be able to request funding for HSS interventions that are consistent with the mandates and financing modalities of Platform funding partners. For the GF, countries will be able to apply for funding for “cross-cutting” HSS interventions, i.e., those that contribute to improved outcomes related to two or all of the three GF target diseases. For GAVI, HSS interventions will need to be linked to immunization outcomes. The WB will continue to cover the full range of HSS support.

Track 2, Option 1 involves new funding via a joint GAVI/GF HSS proposal form, and focuses on countries that have no robust and jointly assessed national health strategy or that prefer to access HSS funds via regular GAVI and/or GF proposals.¹⁰ This joint proposal form is currently being developed and aims to coordinate the separate stand-alone HSS application procedures of the GF and GAVI. In 2005, GAVI introduced a specific HSS funding window that enables countries to submit stand-alone HSS funding requests. At its December 2010 board

meeting, the GF Board also decided to allow countries to submit stand-alone proposals for cross-cutting HSS activities starting with Round 11 (Box 1). Through the Platform (Track 2, Option 1), countries will now be able to request new HSS funding through one single GAVI/GF proposal form that can be used to apply for HSS support from either GAVI or the GF alone, or to make a joint request to both funders.

Proposals to the GF will continue to be submitted by the GF's Country Coordinating Mechanisms (CCMs). The GF intends to expand expertise on HSS in CCMs to ensure that they are able to fulfill their program design and oversight role for HSS programs. Proposals to GAVI will be submitted by countries' national health sector coordination committees (HSCCs). Joint requests to the GF and GAVI will require a joint CCM/HSCC submission.

All country proposals (i.e., separate and joint funding requests) will be reviewed by a joint review body that is made up of members of the GF's Technical Review Panel (TRP) and GAVI's Independent Review Committee (IRC). For joint requests, countries will need to clearly delineate which funding is requested from which funder. The GF and GAVI boards will continue to approve funding separately. Programs will also be managed separately, but will be based on a common fiduciary (i.e., as part of a JFA) and M&E framework and coordinated with the WB and other donors.

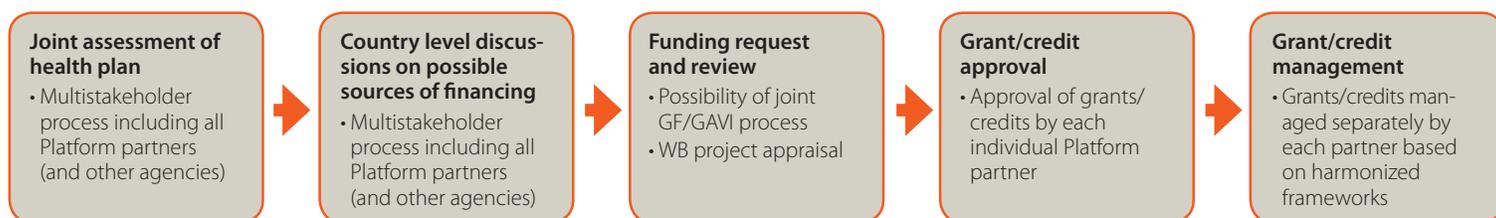
Countries that have completed a JANS have three options for requesting HSS funds from the Platform funding partners:

- Submit a separate funding request to GAVI, or the GF.
- Submit a joint GAVI/GF funding request.
- Request funding from the WB through its existing project appraisal process, which now takes the JANS results into account.

Submissions to GAVI and the GF will require only limited funder-specific information in addition to the national health plans. A joint GAVI/GF funding request template for Track 2, Option 2 is being developed for this purpose (this form is distinct from the joint GAVI/GF proposal form for Track 2, Option 1). Funding requests to the two organizations will be submitted by HSCCs (GAVI) or CCMs in coordination with the HSCCs (GF), and will be reviewed by a joint TRP/IRC review body. The WB does not intend to make any changes in the way countries access funding as a result of the Platform, other than including the results of the JANS in its assessment of country applications.

Once funding is approved by the three Platform funding partners, it will be managed separately by each agency according to its respective policies but based on harmonized M&E and financial management procedures (i.e., within the parameters of a JFA). Partners can still make their own results-based funding decisions.

Figure 2: Key steps in accessing new HSS funding based on national health plans (Track 2, Option 2)



Track 2, Option 2 allows countries to access funding based on jointly assessed national health strategies. In 2011, partners will test this approach in four to five countries. Figure 2 illustrates the key steps in Track 2, Option 2.¹¹

As a first step, countries with robust national health plans must conduct an assessment of their plan, using the JANS approach.¹² The JANS was developed by IHP+ as a way to (a) assess the quality of country strategies in order to strengthen them further, and (b) inform donors' funding decisions. The JANS is a country-driven approach and includes multiple stakeholders (government, civil society, and development partners). It is followed by country-level discussions to identify sources of financing for the national health strategy. These discussions are facilitated by technical partners (e.g., WHO), and are important to ensure that different areas within national health strategies are not overfunded or underfunded.

SECTION 2: CURRENT STATUS OF THE PLATFORM'S IMPLEMENTATION

Following the initial design of the Platform in 2009, the Platform's partners implemented specific elements of it in 2010. Harmonization and alignment of existing HSS support (Track 1) is ongoing in a number of countries:

- GAVI, the WB, and other donors signed a JFA in Nepal in August 2010, following a joint assessment of the country's national health strategy. This JFA brings together donors that pool their funds in support of the health sector strategy and donors that do not.¹³ The GF has not yet taken part in the JFA, because it did not have new approved funding that could have been used to finance specific elements of the strategy. In addition, Nepal's CCM did not request reprogramming of its existing GF grants to support its national health strategy.

- In Cambodia, the Platform funding partners have aligned their performance indicators with those of the government and agreed to jointly strengthen the national M&E system.¹⁴ Platform funding partners are also exploring the streamlining of their fiduciary systems and M&E in Ethiopia, the DRC, and Benin.¹⁵

Platform partners have also developed a report on harmonizing financial management procedures, with a set of recommendations that will be tested in 2011. A report on harmonizing procurement systems is expected in the first half of 2011.

Overall, implementation of Track 1 has been slower than planned, mirroring previous attempts to improve aid effectiveness, which also moved slowly.¹⁶ For *existing* HSS funds, Platform partners had aimed to have the M&E and fiduciary frameworks of existing HSS funding harmonized in four to five countries by the end of 2010.¹⁷ Now, the new target date is June 2011.

For *new funding* under Track 2, GAVI and the GF are in the process of finalizing the joint application materials for Option 1 and 2. Countries will be able to submit joint GAVI/GF funding requests from August 15, 2011, when the GF launches its Round 11 application cycle. The window for submissions closes in December 2011. The submission of separate funding requests to the GF will be possible in the same timeframe (i.e., August–December 2011). However, given that GAVI uses a rolling channel to approve HSS funding requests, a few countries will already be able to apply for HSS funding from GAVI prior to August 2011 using test versions of the joint GAVI/GF application forms. GAVI expects three countries to request HSS funding through the joint proposal form (Option 1), and one country (Ethiopia) to submit an application based on its jointly assessed national health plan (Option 2).

Overall, Platform partners are working together to enable a number of countries to submit funding requests based on jointly assessed national health strategies in 2011. The objective is that by June 2011, four countries will have “either received funding, have submitted a request, or have been invited to submit a request.”¹⁸ There are currently five countries that have conducted a JANS: Nepal, Uganda, Ethiopia, Ghana and Vietnam. These countries are therefore likely to test the approach of accessing HSS funds on the basis of national health strategies.

SECTION 3: LOOKING AHEAD

The Platform is intended to accelerate progress towards MDGs 4–6 through the harmonization and alignment of the three Platform funding partners’ HSS support, and by increasing the resources available for this support. The Platform has the potential to achieve a number of important benefits:

- Combined funding requests should help to reduce transaction costs in the development and assessment of funding requests. HSS funding requests based on the JANS should also provide an opportunity to identify funding gaps and possible sources of financing for the national health strategy.

- Harmonized fiduciary frameworks, as part of JFAs, represent a significant change to the current situation. One financial management framework with one report and one audit should substantially reduce the transaction costs for both HSS recipients and funders. JFAs and annual performance reviews should also contribute to increased transparency of donor and domestic funding, leading to improved oversight.
- Harmonized M&E frameworks, with a single performance framework and harmonized M&E requirements, have the potential to enable better alignment between country and global reporting and to reduce the reporting burden for countries.

While the Platform has the potential to contribute to increased aid effectiveness, a number of unresolved issues will require further attention in the next phase of the Platform’s development.

Pushing the limits of harmonization and alignment

Although it aims to simplify the flow of funding to HSS, the Platform itself, with its different ‘tracks’ and ‘options’, is complex. While Platform funding partners have begun to harmonize their procedures for accessing and managing HSS funding, each agency still maintains its own processes and timing for receiving and approving applications. GAVI can approve HSS funding requests on a rolling basis throughout the year, whereas the GF approves HSS funding only in the context of its “rounds-based” channel (typically the GF issues one round per year). If these differing schedules for submitting proposals are maintained, this will threaten one of the very innovations of Platform: giving countries the opportunity and incentivizing them to submit joint GAVI/GF proposals. If countries need to wait for their joint proposals to be reviewed and approved in the context of a GF round, countries may prefer to stick with separate funding applications to GAVI and the GF. This would allow them to access immunization-related HSS support more rapidly and to align funding requests with country cycles.

As the Platform is rolled out, GAVI and the GF will need to explore ways for creating a better incentive structure for funding requests to be submitted and reviewed jointly. An important question in this context is whether the GF could and should complement its rounds-based channel with a more flexible ‘rolling’ mechanism for reviewing and approving cross-cutting HSS proposals to ensure maximum harmonization and alignment. This mechanism would, however, likely require an earmarked funding pool for stand-alone HSS proposals (as is the case with GAVI). This question of whether the GF should set aside funding specifically for cross-cutting HSS related to the three diseases has been the subject of an ongoing debate within the GF’s governance bodies. It is unlikely that such a proposal would find majority support in the near future.

Even if the GF and GAVI were to find a way past these challenges, the WB as the third actor will most likely retain its separate processes and timelines given its very different business model.

It seems likely, therefore, that the full potential for harmonization of application processes within the Platform and their alignment with country cycles will remain unexploited for the time being.

A further potential challenge to a well coordinated approach to HSS funding arises from the fact that the GF and GAVI will continue to allocate HSS funds through channels other than the Platform. The GF allows applicants to integrate HSS funding requests into disease-specific funding requests (which could be regular disease proposals or National Strategy Applications), and GAVI channels some of its HSS funds through its IRIS window (Box 1). It will be critical to ensure that these integrated streams of HSS funding to countries are optimally coordinated with stand-alone HSS applications by the same countries. Managing this added complexity will be no trivial task.

Ensuring a balanced allocation of HSS funding support

Achieving large-scale, sustainable health outcomes will require significant cross-cutting and sector-wide investments in countries' health systems over the next few years (e.g., for large-scale expansion of the health workforce; creation and maintenance of health infrastructure; and strengthening the policy-making capacity of the health ministry). GAVI and the GF cannot address these HSS bottlenecks alone: their existing scope for HSS funding is too narrow, and focuses largely on removing barriers to service delivery relating to immunization, HIV, TB, and malaria.¹⁹ Both organizations also share limitations stemming from their roles as financing instruments rather than implementing entities (e.g., limited in-house technical capacity, limited direct engagement with countries). Health systems improvement will require substantial in-country expertise and capacity to meet country needs.

Overcoming these bottlenecks is an area where the WB could make a major contribution to the Platform. It could finance the entire spectrum of HSS, engage in countries' national policy dialogues, and link health sector reform to macroeconomic issues.²⁰ However, as a recent WB evaluation shows, the WB's support for HSS to date has been relatively weak.²¹ A critical prerequisite for the Platform's success will therefore be for the WB to step up both the quantity and quality of its financing support for HSS, especially as it relates to broader cross-cutting and system-wide HSS. Such a move would go a long way in moving toward creating a balanced allocation of HSS financing based on each of the three Platform funding partners' comparative advantages.

Even then, there will remain gaps in what will readily be financed through Platform funding partners. With the GF Board's recent decision not to further venture into maternal, neonatal, and child health (MNCH),²² it is unclear how the delivery of key MNCH interventions and associated HSS needs will be financed. Contributions by bilaterals and other funders will be critical in filling this and other gaps. HSS is a focus area of key bilateral agencies (e.g., USAID and DFID), and they could also fund the broader system-wide support that will be required to reach MDGs 4–6. However, there is no clear strategy for engag-

ing bilaterals in joint country arrangements. While the Platform framework facilitates discussion between donors on HSS funding areas based on the joint assessment of national health plans (Option 2), it is unclear how a balanced allocation of HSS funding will be achieved in countries where this joint assessment does not yet exist (Option 1).

Eventually all HSS support could be based on the joint assessment of national health plans to ensure that key HSS bottlenecks will be covered (Track 2, Option 2). In the interim, ensuring a balanced allocation of HSS funding in countries without a quality-assured national health plan will remain a challenge. Without a dedicated in-country mechanism for coordinating HSS, it is likely that HSS funding will be biased towards disease-specific service delivery, whereas system-wide support is likely to remain neglected.²³ One way forward may be for Platform partners to more systematically join existing harmonization and alignment arrangements at the country level, such as Sector-Wide Approaches (SWAs).²⁴

Mobilizing additional resources for HSS

When the Platform was launched in 2009, donors were expected to pledge large amounts of new funding dedicated to the Platform and HSS. So far, the governments of Australia, Norway, and the UK have pledged almost \$900 million through an expanded International Finance Facility for Immunization, which will be channeled through GAVI and will provide about \$475 million for GAVI's HSS programs between 2011 and 2015. Norway and the UK have pledged \$450 million for results-based programs through the WB, and it is expected that parts of this funding will be coordinated under the Platform.²⁵ Although this is significant funding, it falls very short of the estimated \$122 billion required for HSS in 49 low-income countries between 2011 and 2015 to reach MDGs 4–6.²⁶ Without new resources, the Platform faces a high risk of failing to meet expectations. Mobilizing new HSS funding for Platform activities will be a challenge in the current resource-constrained environment, particularly given that GAVI and the GF already face challenges funding their current mandate and that the Platform has yet to prove that it works.

Strengthening Technical Assistance (TA)

Preparation and implementation of successful proposals for HSS under the Platform will depend on well-coordinated, quality TA within countries. Yet, evaluations of both GAVI and the WB indicate that TA was weakest for their HSS programs, and that much stronger efforts are required to support countries in the design and implementation of HSS projects.²⁷ Currently, it is unclear which concrete steps will be taken to ensure coordinated, targeted and quality-assured provision of TA. As the Platform moves forward on program implementation in many countries, an important step will be to lay out a clearly-articulated plan for how harmonized, high-quality TA will be provided and financed. This is an area where WHO could and should provide leadership.

Monitoring and Evaluation (M&E)

A critical factor in determining the success of the Platform will be appropriate indicators and M&E systems that enable (a) tracking of whether HSS investments lead to improved health systems and health outcomes, and (b) the application of performance-based financing. While Platform partners released a broad framework for the M&E of national health strategies in October 2010, the framework does not yet include a set of agreed, global core indicators to measure progress towards specific agreed outcomes. Creating a set of core indicators will be important to provide clearer guidance for countries as they develop their national M&E frameworks and funding requests. These core indicators would also allow for better comparison of outcomes achieved by HSS investments and for streamlining of M&E across Platform partners and countries.

At the country level, Platform partners plan to work with countries using the Country Health System Surveillance (CHeSS) approach, developed by IHP+, to create a functioning

monitoring and surveillance system.²⁸ Platform partners need to invest further in countries' capacity to create these surveillance systems to produce data of sufficient quality and to permit the regular tracking of progress in scaling-up HSS.

CONCLUSION

Although the Platform has a number of benefits, its institutional arrangements are still complex and hard for recipient countries to understand and navigate. This complexity seems to be driven by a wish to maintain the current global health architecture with minimal changes to existing institutions. And yet, it is boldness and openness to a more radical realignment of existing structures and models that will be critical in realizing the full potential of the Platform.

AUTHORS

This Policy Brief was written by Marco Schäferhoff, Christina Schrade, and Gavin Yamey.

COMPETING INTERESTS

E2Pi is a partnership between the Global Health Group (GHG) at the University of California, San Francisco and SEEK Development, Berlin. It is supported by a grant from the Bill & Melinda Gates Foundation. E2Pi was recently contracted by the GF to estimate "success benchmarks" in the Affordable Medicines Facility-malaria (AMFm). CS is a former manager at the GF, and has consulted for GAVI. GHG's Executive Director, Richard Feachem, is the former Executive Director of the GF and former Director for Health, Nutrition and Population at the WB.

REFERENCES

- ¹ A series of documents outlining the framework have been collected together at <http://go.worldbank.org/0D4C6GPQU0>
- ² http://www.oecd.org/document/18/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html
- ³ http://www.oecd.org/document/3/0,3746,en_2649_3236398_41297219_1_1_1_1,00.html
- ⁴ www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf
- ⁵ Joint HSS Working Group: Principles Guiding Joint Programming and a Funding Platform for Health System Strengthening: Notes from the WB, GAVI, Global Fund, and WHO Geneva Meeting August 20–21 2009. Available at: <http://tiny.cc/2nr4e>
- ⁶ Mapping Resources for Health Systems Strengthening: Current Situation and Future Challenges. Briefing paper prepared for the World Bank, Global Fund to Fight AIDS, Tuberculosis and Malaria, and GAVI Alliance Technical Workshop on Health Systems Strengthening, Washington DC, June 25–27, 2009. Available at: <http://go.worldbank.org/S4D40I3LK0>
- ⁷ GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, and the World Health Organization: Health Systems Funding Platform (HSFP) – Work Plan October 2010 – June 2011. Available at: <http://go.worldbank.org/U95D6U9G60>
- ⁸ Previously cross-cutting HSS applications had to be linked to a disease specific grant. Only in Round 5, the GF allowed the submission of stand-alone HSS proposals.
- ⁹ The World Bank: Implementation of the World Bank's Strategy for Health, Nutrition, and Population (HNP) Results: Achievements, Challenges, and the Way Forward. Progress Report, March 19, 2009.
- ¹⁰ See HSFP Work Plan (reference 7).
- ¹¹ See HSFP Work Plan (reference 7).
- ¹² The JANS approach is described at the IHP+ website: www.internationalhealthpartnership.net/en/about/j_1253621551

- ¹³ Pooling donors are the WB, DFID, and GAVI. Donors that do not pool their funds are USAID, UNFPA, and UNICEF. See: GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, and the World Health Organization: Implementing the Platform—Country Update Document, Oct. 2010. Available at: <http://go.worldbank.org/U95D6U9G60>
- ¹⁴ GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, and the World Health Organization: Briefing note. Consultation with the Royal Government of Cambodia on implementation of the Health Systems Funding Platform. Available at: <http://go.worldbank.org/U95D6U9G60>
- ¹⁵ See Implementing the Platform—Country Update Document, Oct. 2010 (reference 13).
- ¹⁶ OECD: Aid Effectiveness—A Progress Report on Implementing the Paris Declaration, 2009. Available at: http://www.oecd.org/document/16/0,3746,en_2649_3236398_41726352_1_1_1_1,00.html
- ¹⁷ See HSFP Work Plan (reference 7).
- ¹⁸ See HSFP Work Plan (reference 7).
- ¹⁹ Schrade C, Yamey G, Schäferhoff M: Packages of Care. A Pragmatic Approach to Exploring An Enhanced Role of the Global Fund in Maternal, Newborn and Child Health. E2Pi, Working Paper, December 2010. Available at: <http://globalhealthsciences.ucsf.edu/GHG/e2pi.aspx>
- ²⁰ Shakow A: Global Fund – World Bank HIV AIDS Programs. Comparative Advantage Study, 2006. England R: The GAVI, Global Fund, and World Bank joint funding platform, in: Lancet 2009; 374:1595–6. See also: Levine R: Wedding bells for GAVI, the World Bank and the Global Fund? Available at: <http://blogs.cgdev.org/globalhealth/2009/07/wedding-bells-for-gavi-the-world-bank-and-the-global-fund.php>
- ²¹ Independent Evaluation Group (IEG): Improving Effectiveness and Outcomes for the Poor in Health Nutrition and Population. An Evaluation of World Bank Group support to Health, Nutrition and Population (HNP) (2009); Shakarishvili, G et al.: Health systems strengthening: a common classification and framework for investment analysis, in: Health Policy and Planning, Oct 2010 doi:10.1093/heapol/czq053
- ²² At the 22nd GF Board meeting, the Board decided not to expand the GF's mandate to enhance its contributions to maternal, newborn, and child health (MNCH) due to the risks associated with a mandate expansion (e.g., “cannibalization” of funding for the three diseases). See: http://www.theglobalfund.org/documents/board/22/BM22_DecisionPoints_Report_en.pdf
- ²³ HLSP: GAVI Health Systems Strengthening Support Evaluation 2009. Volume 1: Key Findings and Recommendations, Oct. 2009.
- ²⁴ However, as the 2010 evaluation of the WB's HNP support found, SWAps are associated with mixed results at best. See: Independent Evaluation Group 2009 (reference 21).
- ²⁵ See: http://gavistg4.elca-services.com/resources/Health_Systems_Funding_Platform.pdf; Norway had already pledged an additional \$100 million to the WB's results-based trust-fund in 2007.
- ²⁶ United Nations Secretary-General (with support and facilitation by The Partnership for Maternal, Newborn & Child Health): Global Strategy for Women's and Children's Health. <http://www.who.int/pmnch/activities/jointactionplan/en/index.html>
- ²⁷ See reference 2: GAVI Health Systems Strengthening Support Evaluation (see reference 23).
- ²⁸ See: http://www.who.int/healthinfo/country_monitoring_evaluation/en/index.html

E2Pi | EVIDENCE TO POLICY INITIATIVE

The Evidence to Policy Initiative (E2Pi) is a new global health policy collaboration, which conducts independent analysis and evidence synthesis to inform discussion and decision-making on critical policy and strategic issues in global health.

E2Pi.org

E2Pi is funded by grants from the Bill & Melinda Gates Foundation and the New Venture Fund.

 Copyright E2Pi under the Creative Commons Attribution-NonCommercial-ShareAlike License.