Health System Strengthening (HSS) Cash Support

Application Package – Proposal Form

COUNTRY NAME: Central African Republic Application Date: 1 June 2015

This proposal form is for use by applicants seeking to request Health System Strengthening (HSS) cash support from Gavi, the Vaccine Alliance (Gavi). Countries are encouraged to participate in an iterative process with Gavi partners, including civil society organisations (CSOs), in the development of HSS proposals prior to submission of this application for funding.

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Gavi's Key Elements for Health System Strengthening Grants

The following key elements outline Gavi's approach to health system strengthening and should be reflected in an HSS grant. They are presented as being either 'required' for a Gavi HSS Grant or 'recommended' for a Gavi HSS Grant:

1. **Required Elements:**

- One of Gavi's strategic goals is to "contribute to strengthening the capacity of integrated health systems to deliver immunisation". The objective of Gavi HSS support is to address system bottlenecks to achieve better immunisation outcomes, including increased vaccination coverage and more equitable access to immunisation. As such, it is necessary for the application to be based on a strong analysis of the bottlenecks and gaps and present a clear results chain demonstrating the link between proposed activities and improved immunization outcomes.

- Performance based funding (PBF) is a core approach of Gavi HSS support. All applications must align with the Gavi performance based funding approach introduced in 2012. Countries' performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes. Under the PBF approach for HSS, the programmed portion of HSS grants must be used solely to fund HSS activities. Countries have more flexibility on how they wish to spend their reward payments, as long as they are still spent within the health sector. Neither programmed nor performance payments may be used to purchase vaccines or meet Gavi's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

- Gavi's HSS application requires a strong M&E framework, measurement and documentation of results, and an end of grant evaluation. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes including DTP-HepB-Hib3 coverage, measles-containing vaccine first dose (MCV1) coverage, fully immunised child coverage, difference in DTP3-HepB-Hib3 coverage between top and bottom wealth quintiles, and percent of districts reporting at least 80% coverage of DTP-HepB-Hib3. Additionally, so as to systematically measure and document immunisation data quality and data system improvement efforts, independent and recurrent data quality assessments and surveys will be required for all HSS applications.

- Gavi's approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to Gavi. Gavi requires that countries have in place routine mechanisms to independently assess the quality of administrative data and track changes in data quality over time. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, and to demonstrate how their grant will be used to help implement recommendations or agreed action items coming from previous data quality assessments. The process of conducting periodic data quality assessments and monitoring trends should be credible and nationally agreed. For example, incorporating an independent element to the assessments could involve national institutions that are external to the programme that collects or oversees the data collection. Comprehensive information on reporting and data quality requirements are provided in the NVS/HSS General Guidelines for 2015. Please refer to section 3 on Monitoring and Reporting and Annex E on Data Quality.

- Gavi recognises the importance of effective and efficient supply chain systems for the management of existing and new vaccines and health commodities. Gavi has therefore developed and approved in June 2014 a supply chain strategy.[1] (For more information about the strategy initiatives, see the factsheet [http://www.gavi.org/Library/Publications/GAVI-fact-sheets/Gavi-Supply-Chain-Strategy/]). The Effective Vaccine Management (EVM) assessment and improvement plan are essential steps in the strategic approach to supply chain improvement in countries.

- New Requirement: As approved by the Gavi Board in June 2014 all future proposals (2015 and beyond) that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure pre-qualified equipment by WHO through the Performance Quality and Safety (PQS) programme. The purchase of non-PQS pre-qualified equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

[1] See section 3.5 of GAVI's supply chain strategyhttp://www.gavi.org/About/Governance/Gavi-Board/Minutes/2014/18-June/Minutes/05---Gavi-Alliance-immunisation-supply-chain-strategy/

- Gavi supports the principles of alignment and harmonisation (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how Gavi support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in the supplementary HSS guidelines.
- Gavi requests countries to identify and build linkages between HSS support and new vaccines implementation (Gavi NVS) – linkages to routine immunisation strengthening, new vaccine introduction, and campaign planning and implementation must be demonstrated in the application. Countries should demonstrate alignment between HSS grant activities and activities funded through other Gavi cash support, including vaccine introduction grants and operational support for campaigns.
- As part of vaccine introduction, Gavi HSS support should be used during pre-and post-introduction for strengthening the routine immunisation system to increase the coverage e.g. through social mobilisation, training, supply chain management etc. (see grant categories in table 1 of the Supplementary HSS Guidelines) for all the vaccines supported. This should complement other sources of funding including vaccine introduction grants from Gavi.
- Applications must include details on lessons learned from previous HSS grants from Gavi or support from other sources such as previous New and Underused Vaccine Support, the EVM assessment or PIE tools, EPI reviews etc.
- Applications must include information on how sustainability of activities and results will be addressed from a financial and programmatic perspective beyond the period of support from Gavi.
- Applications must include information on how equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the complementarity and added value of Gavi support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources and relative to other funding from Gavi specific to new vaccines and/or campaigns.

2. Recommended Elements:

- Gavi supports the use of Joint Assessment of National Strategies (JANS). If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.
- Gavi's approach to HSS includes support for community mobilisation, demand generation, and communication, including Communication for Immunisation (C4I) approach.
- Gavi supports innovation. Countries are encouraged to think of innovative and catalytic activities for inclusion in their grants to address HSS bottlenecks to improving immunisation outcomes.
- Gavi strongly encourages countries to include funding for CSOs in implementation of Gavi HSS support to improve immunisation outcomes. CSOs can receive GAVI funding through two channels: (i) GAVI sends funds to the Ministry of Health which then transfers them to the CSO, or (ii) GAVI sends funds directly from GAVI to the CSO. Please refer to Table 1 for potential categories of activities to include in budget for CSOs and Annex 4 of the Supplementary HSS Guidelines for further details of Gavi support to CSOs.
- Recommended: Countries can incorporate new strategy elements in their NVS and HSS proposals that begin to address the three key elements of supply chain management fundamentals (supply chain managers, supply chain performance dashboards, and comprehensive supply chain management plans) and can use existing resources such as:
    - The EVM, EVM improvement plan and the Progress report on the EVM improvement plan which shall be submitted with applications, if available; and, which should contribute to providing evidence on the existing cold chain status and the country plans to address supply chain bottlenecks and inform the development of a comprehensive supply chain management plan.
- While Gavi's current PBF approach is applied to HSS grants at the national level, Gavi also encourages

countries to consider using performance-based funding at sub-national levels. Where appropriate, countries may decide to align with other PBF programmes, such as the World Bank's results-based financing (RBF) programmes, and if so, sufficient information must be included with the Gavi HSS proposal on how funding will be aligned. If aligning to a World Bank RBF programme, please provide the concept note or programme design document. Describe which of the objectives of the grant are for the PBF/RBF programme. Please also attach the results framework and budget for the RBF programme. Please note that more than one immunisation-related indicator is expected to be part of any such PBF/RBF programme, if the Gavi HSS grant is proposed to be aligned with it (please see part IV of the Introduction to the Supplementary HSS Guidelines).

- Applicants are encouraged to identify technical assistance (TA) and capacity building needs for implementation and monitoring of the HSS grants. Applicants are required to include details of short term and long term TA if they are requesting TA as part of the HSS application to ensure strong implementation and effectiveness of Gavi HSS support.

PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

i. Checklist for a Complete Application

A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary.

HSS Proposal Forms and Mandatory Gavi attachments		
No.	Attachment	
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	X
3.	Minutes of HSCC meeting endorsing Proposal	X
4.	Minutes of three most recent HSCC meetings	X
5.	HSS Monitoring & Evaluation Framework	X
6.	a. Detailed budget, gap analysis and work plan b. Calculation basis: GAVI HSS application 2016-2018	X
7.	Detailed Procurement Plan (18-month)	X

Existing National Documents - Mandatory Attachments		
No.	*Attachment*	
8.	a. Health Sector Transition Plan (HSTP); b. NHDP II 2006-2015 (reiterated in the HSTP).	*X*
9.	National M&E Plan (for the health sector/strategy) **Not available**	
10.	National Immunisation Plan **Not available**	
11.	a. Country Comprehensive Multi-Year Plan for Immunisation (cMYP), 2011-2015 b. 2015-2017 cMYP currently being finalized	*X*
12.	a. Effective Vaccine Management (EVM) Assessment report (from an EVM conducted within the preceding 36 months). b. EVM Assessment in September, 2011 Next EVM included in this application's activities for 2016; c. Recommendation implementation report; d. Update EVM improvement plan - September 2014.	*X*
13.	Terms of Reference (TOR) of Health Sector Coordinating Committee (HSCC)	

Existing National Documents - Additional Attachments		
No.	*Attachment*	
14.	Joint Assessment of National Health Strategy (JANS); **Not available**	
15.	Response to the Joint Assessment of National Health Strategy (JANS) **Not available**	
16.	If funds transfers are to go directly to a Civil Society Organisation (CSO) or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor Not applicable	
17.	Supply and inventory management plan for drugs and medical devices. **Not applicable**	
18.	Cold chain equipment inventory list and/or cold chain storage capacity analysis. **Not available**	
19.	Coverage improvement plan. **Not available**	
20.	Equity analysis and plan.	X
21.	Evaluation of previous HSS grant **Not available**	
22.	List of target populations/districts, and criteria for selection Target districts with demographic data	X
23.	Post Introduction Evaluation Report Not available	

24.	EPI Review/evaluation Report	X
25.	Report from last completed household survey **Not available**	
26.	Concept note or programme design document (including results framework and budget) of any World Bank Results-Based Financing (RBF) programme, or other PBF/RBF programme document, if the Gavi HSS grant is proposed to be aligning with such programme. Not available	
27.	2014 HeRAMS Report	X
28.	Reprogramming of 2014 - -2015 HSS/GAVI	X
29.	2015 EPI action plan (draft)	X
30.	Draft of the ruling governing the creation, operation and organization of the Strategic Partnership Framework for Health.	X
31.	Draft of the ruling governing the operation and organization of the Permanent Technical Secretariat for the Strategic Partnership Framework for Health.	X
32.	Emergency and Sustainable Improvement Program (in French: PURD) in the CAR, 2014-2016	X
33.	Strategic Poverty Reduction Strategy Document (SPRSD II) 2011-2015	X
34.	Cold chain inventory and gap analysis 2014.	X
35.	WHO/UNICEF Joint Reporting Form)JRF) on Immunization activities, 2013	X
36.	Report on the multiple indicator cluster study (MICS IV-2010)	X
37.	Standards (for MPA and CPA) in health districts-2010	X
38.	2012-2016 strategic plan for the United Nations Systems in the CAR (UNDAF)	X
39.	a. Directives on free care b. Appendix on directives on free care	X
40.	Report on EPI directors' mission to Douala	X
41.	2015 budget for outreach strategies	X

1 1. Applicant Information	
Applicant:	Ministry of Health and Population
Country:	Central African Republic
Proposal title:	Health System Strengthening Support (HSSS)
Proposed start date:	*January 2016*
Duration of support requested:	*3 years*
Total funding requested from Gavi:	7,560,000 $US
Contact Details	
Name:	Dr Peggy Raymonde CONJUGO-BATOMA
Organisation and title:	Directorate of Research and Planning
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Telephone:	Tel: +236 75 03 33 09 / +236 70 40 78 34
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E-mail addresses:	pegconj@gmail.com ; pegconj@yahoo.fr

2 The Proposal Development Process

The Directorate of Research and Planning was assigned to design the application. In theory, the Ministry of Health has a Sectoral Health Committee for HIV/AIDS (SHC-HIV/AIDS), created by the Prime Minister's decree of 25 July 2008, which is responsible for preparing and validating policies for any health systems strengthening strategy. However, this committee needs to be revived. In addition, a Strategic Partnership Framework for Health (SPFH), responsible for submitting strategic recommendations (with no decision-making power) in the context of the Health Sector Transition Plan (HSTP) has been in the process of being formed since December, 2014, is still not operational.

In this context, a document-writing committee was created by Service Memo No. 956 MSPAFPGAH/DIRCAB/DGSCEH/DEP on 30 October 2014, to prepare the application.

The EPI Technical Support Committee was directed to validate the technical aspects of the application prepared the by the document-writing committee.

The Inter-Agency Coordinating Committee did the final validation of the application in January 2015, and the second application in May 2015.

At the central level, the Directorate of Research and Planning collaborated closely with the Directorate of Family Health and Population, the EPI Directorate, the Directorate of Health Communication, the Directorate of Health Infrastructure Development and the Directorate of Resources. All of these directorates work together to fully and equitably develop the health sector.

However, the contributions of the decentralized levels was relatively limited. This is caused primarily by the low level of functioning of the Region and District management teams, related to the departure of a significant percentage of staff, due to the conflicts that have affected the country since December, 2012. This proposal intends only to work to revive MPH entities at the decentralized level, in application of the HSTP. However, most of the Regional Directors and some of the Chief Physicians in the Prefectures/Districts/Health Divisions have contributed to the proposal's technical validation meetings.

Likewise, CSO participation primarily involved the participation of ASSOMESCA, the association for medical work for health in Central Africa, throughout the process: from writing to technical validation to approval of the proposal. The reasons for these limitations are similar: the structure for associations in the CAR has been completely

destroyed by the conflicts and by population displacement. Note that for 20 years, ASSOMESCA has been, by far, the primary national CSO in the CAR, with a large network of faith-based health facilities and pharmaceutical storage locations.

The following partner organizations supported the preparation of this proposal: the World Health Organization (WHO), the United Nations Childrens' Fund (UNICEF), and the United Nations Population Fund (UNFPA). In addition, the following organizations also reviewed the proposal before its submission to Gavi: The European Union, the French Development Agency and the World Bank. The WHO also provided technical assistance on three occasions: for the first application in December 2014, for the second and third applications in January 2015, to improve the writing and the additional sections 1-22, and 15-16, and the attached files associated with these after the pre-review was completed in Geneva.

Preparations for the Gavi-HSS proposal began on 16 May 2014 after a joint meeting with the Department authorities and its primary partners, after which a statement of interest aimed at submitting a request to strengthen the Central African Republic's health systems was submitted to Gavi Alliance.

After a series of contacts between key partners (the government, WHO, UNICEF, UNFPA), the statement of interest was followed by the creation of a document writing committee on 30 October 2014. This multi-disciplinary document writing committee is composed of the director of the Directorate of Research and Planning, the EPI director, the departmental director of Health Information and Statistics, the Gavi-HSS project manager, the Monitoring and Evaluation manager of the Directorate of Family Health and Population, the director of Preventive Medicine and Disease Prevention, two representatives from the WHO, two representatives from UNICEF and two representatives from the UNFPA. The multidisciplinary document writing committee was responsible for coordinating the various activities inherent in the writing process; assembling the required documentation and identifying technical assistance needs, then involving the Health Sector HIV Coordinating Committee (HSCC) through the preparation of a roadmap funded by the WHO, for a total of 22 million xxx [sic] CFA francs.

The document writing committee coordinated the process, from writing the application documents to submitting them to the Gavi Alliance Secretariat. That committee will respond to all requests for clarification until Gavi Alliance's final response is received.

A preliminary version of the application was peer-reviewed in Libreville from 17 to 20 November 2014, during a meeting of the Central Africa Inter-country Support Team, the WHO regional office (AFRO), the WHO headquarters, Gavi Alliance and the eligible countries.

The items were assembled into an initial draft which received International Technical Assistance supported by the WHO, consisting of a consultant from xx December 2014 [sic] to 2 January 2015.

The document was then presented to a larger audience during a meeting organized at the Hotel Azimut from 13 to 22 January, involving, in addition to managers from the various levels of the health system, managers from the Ministry of Planning and Finance, delegates from civil society organizations, NGOs, WHO, UNICEF and UNFPA. A smaller technical team (MPH, UNICEF, WHO, CSOs) finalized the proposal, from 23 to 25 January 2015.

The Ministry of Health was aware of the potential that a sub-optimal document would be submitted. Throughout the process of preparing the application, the volatile security situation made it impossible for the team to work in peace. In addition, the delayed availability of consultants to finalize the budget process for the Gavi/HSS proposal and the cMYP 2015-2019 required the Ministry of Health to send a letter to Gavi Alliance to request that the review of the Central African Republic's documents be delayed. That was not possible, so the document was submitted for a pre-review organized in Geneva in February 2015, which addressed a series of technical recommendations that were sent.

The document writing committee went back to work in March 2015, and received additional technical support from the WHO, in the form of international consulting in April 2015 (one person for correcting and improving the document). The document writing committee continued preparing the document at the end of April, to complete the budgeting tool and to thus complete the associated narrative information.

The document was submitted to the EPI Technical Support committee on 30 April 2015, then presented to the ICC for approval on 8 March 2015, then presented to the WHO pre-review team in Geneva at the beginning of May 2015.

The final corrections were made during the second half of May, approved by the ICC and submitted to GAVI on 15 May 2015.

Signatures: Government endorsement

Please note that this application will not be reviewed or approved by Gavi without the signatures of both the Ministers of Health & Finance and their delegated authority.

Minister of Health	Minister of Finance
Name: Dr Marguerite SAMBA-MALIAVO	Name: Mr Abdallah KADRE ASSANE
Signature:	Signature:
Date:	Date:

Signatures: Health Sector Coordinating Committee endorsement

We the members of the ICC, HSCC, or equivalent committee met on _____ to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Minister/Ministry of Health and Population	Dr Marguerite SAMBA-MALIAVO		
Secretary	Director of Research and Planning/Ministry of Health and Population	Dr Peggy Raymonde CONJUGO-BATOMA		
MOH members	Director General of Public Health	Dr Thomas d'Aquin KOYAZEGBE		
MOH members	Director General of Central Services and Hospital Facilities	Pr Eugène SERDOUMA		
Development partners				
CSO members	CONASAN coordinator	Mr François DEWENBONA LEGUE		
WHO	WHO Representative	Dr Michel N'da Konan YAO		
UNICEF	UNICEF Representative	Mr Mohamed Malick FALL		
UNFPA	UNFPA Representative			

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes ☐ No ☒

Individual members of the HSCC may wish to send informal comments to: gavihss@gavi.org
All comments will be treated confidentially.

Part B – EXECUTIVE SUMMARY

Since the end of 2012, the Central African Republic (CAR) has been in a major military and security crisis, which has caused significant population displacement, a destabilization of health care organizations, and growing national dependence on non-governmental organizations (NGOs) and technical and financial partners (TFPs) to fund public health services. Concerning vaccination, this has resulted in the destruction and pillaging of health infrastructures and inputs, a nearly complete stoppage of health services including vaccination services, the displacement of health personnel, and the loss of the ability to prepare for and respond to epidemics.

Under these conditions, in 2014, CAR received a Gavi-HSS support grant that will run through June 2015, to recenter the remaining funding on a series of priorities adapted to changes in the country's context, and conditions that are specific to operations and safety.

In January, 2015, the CAR submitted a preliminary request for a new grant, and it received a customized approach based on the country's specific conditions. Following the comments on the pre-review provided by the WHO in Geneva in February 2015, it was determined that the document would be corrected before being submitted to the IRC in June 2015, requesting three years of funding with a budget of US $7.56 million.

The country's situation has stabilized somewhat, but the military and security context is still unpredictable. The new application is therefore a continuation of the 2014-2015 reformulation, but with a more targeted focus on institutional strengthening and integration of services. In comparison with the 2014-2015 reformulation, the progress of this application is primarily in the following components:

- Integration into a broader strategic framework. The formulation is part of the implementation of recent strategic documents, firstly the Health Sector Transition Plan (HSTP) 2015-2016, approved in March, 2015, and the cMYP 2015-2017, which is being finalized.
- Focus on coordination. In a context of financial and operational dependence on partners, coordinating joint strategies has become essential (HSTP, 2015-2016).
- Integrated health care approach. The Gavi-HSS project supports the re-launch of the Minimum Package of Activities, which includes but is not limited to vaccination activities. This also involves support for health centers and health posts, and not only EPI centers.
- Support for decentralization. The regional and district framework teams must be restored to their role of governance and local support, as compared to the current centralization model.

The primary constraints that led to these choices are:

(1) The service offerings are fragmented and the quality is insufficient. This is an obvious result of the damages that the conflicts have inflicted on the public, health care employees and the infrastructure. It is also a consequence of a delayed and poorly applied definition of the MPA. Thus, we must work to implement this, by supporting health system strengthening, through its human resources, infrastructure and equipment, cold chain and procurement components.

(2) Financial resources are insufficient and unpredictable. Interventions must complement many other interventions; these are currently poorly coordinated and poorly documented. This question is a large-scale one, and must be discussed within the entity responsible for cooperation around the HSTP.

(3) Health information is not reliable and is not used for decision-making. HR gaps on various levels have made management difficult. The HSTP made epidemiologic surveillance a priority; this extends to vaccination data.

(4) Coordination mechanisms have gaps at all levels of the health pyramid. The emergency situation led to a juxtaposition of poorly coordinated approaches. The HSTP and the cMYP open up the possibility of developing joint approaches.

In terms of intervention zones, this formulation includes health regions 1, 2 and 3 in the western half of the country; they are currently supported in the context of the 2014-2015 reprogramming. This is a response to

safety/accessibility criteria which are essential in the current context, as well as to population density criteria, to optimize program results in terms of increasing the country's overall vaccination coverage. This is also a response to concerns about geographic equity, with the inclusion of region 3, which shows particularly alarming indicators in terms of functionality and delivering services, as compared with the rest of the country (see HeRAMS study). In CAR, there is no significant different in vaccination rates based on gender, and the population's state of deprivation subsequent to the conflict makes the need for support and socio-economic balance nearly universal, outside a few isolated areas in Bangui.

The program objectives are directly in line with the primary constraints that have been identified. They are formulated as follows:

(1) Strengthen governance and coordination of vaccination activities at the central, regional and peripheral levels (US $1,439,444).
(2) Ensure the conditions and quality of curative and preventive health care and health promotion activities, in compliance with the Minimum and Complementary Packages of Activity, including vaccination in health regions 1, 2 and 3 (US $4,311,231).
(3) Improve the quality and use of health information for epidemiologic surveillance and the EPI (budget of US $413,416).

The proposed management methods mark a return of the MPH's leadership in the financial coordination of the Gavi-HSS program, in comparison to the reprogramming, in which funds were allocated to UNICEF. A Project Management Unit (PMU) is being strengthened for this purpose, under the authority of the Directorate of Research and Planning, under the direction of the ICC. The institutional framework extends to the role played by the Strategic Partnership Framework for Health and the implementation of the HSTP, which has become a key contact for the ICC for all dimensions of HSS, for vaccination, and for managing complementarity with all other present and future interventions.
UNICEF and the WHO remain preferred partners, UNICEF for all issues related to procurement, some renovations, cold chain equipment and materials; the WHO for all institutional support activities.
CSOs are active in the program, specifically through participation in coordination bodies at the central and peripheral levels, monitoring community activities, and also in management entities and coordination bodies that are specific to the public health system.
Transparency rules in effect in CAR are applicable to the program, specifically with two-signature systems (MPH+WHO) for all disbursement requests, regular reports to the ICC and external and internal audits on an annual basis.

3 Executive Summary

4 Acronyms

Acronym	Acronym Meaning
ASSOMESCA	Association des Œuvres Médicales pour la Santé en Centrafrique (Association of Medical Work for Health in the Central African Republic)
IVA	Intensive Vaccination Activity
ICC	Inter-Agency Coordinating Committee
HSCC	Health Sector Coordinating Committee
CPEV	EPI Center
CS	Health Centre
CSS-VIH/SIDA	Sectoral HIV/AIDS Committee
CTAPEV	Technical Committee for the EPI
DEP	Directorate for Planning and Research
DIRCAB	Office Director
DGSCEH	Directorate General of Central Services and Hospital Facilities
PRSP:	Poverty Reduction Strategy Paper
ECD	Equipe Cadre de District [District Management Team]
RMT	Equipe Cadre de Region (Regional Management Team)
DHS	Enquête Démographique et de Santé [Demographic and Health Survey]
FOSA	Health Facility
GAVI	Global Alliance for Vaccines and Immunization
EVM	Effective Vaccine Management
GT	Thematic Group
HeRAMS	Health Resources Availability Mapping System
MNP	Manager of National Programs
MSP	Ministry of Health and Population
WHO	World Health Organization
ONG	Nongovernmental Organization
CPA:	Complementary Package of Activities
EPI	Expanded Programme in Immunization
MPA	Minimum Package of Activities
HP	Health Outpost
RSVP	Regional Strategic Vaccination Plan
TFP	Technical and Financial Partner
HSTP	Health Sector Transition Plan 2015-2016
PURD	Plan d'Urgence et de Relèvement Durable du Gouvernement de RCA (Emergency and Sustainable Improvement Program of the CAR government)
APR	Annual Progress Report
CAR	Central African Republic
HR	Health Region
HSS	Health Systems Strengthening
PMU	Project Management Unit
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund

PART C– SITUATION ANALYSIS

5 Key Relevant Health and Health System Statistics

Vaccines Currently Used by the Immunisation Programme

Vaccine product	Year of introduction	Comments (including planned product switches, wastage etc.)
BCG	1979	
OPV	1979	
Pentavalent (DTP-HEPB-HIB-HepB+Hib)	2008	
MCV	1979	
YFV	1979	
TT/DT	1979/2014	The DT was introduced in 2014 to replace the TT
PCV13	*2011*	

Vaccines Planned for Future Use by the Immunisation Programme

Vaccine product	**Month / Year of Introduction**	**Comments**	**Plan for vaccine introduction taken into account in HSS application? If not, why not?**
Rotavirus vaccine (ROTARIX)	June 2016	(02 dose vial)	Yes
IPV	September 2015	(05 dose vial)	Yes
MenAfriVac	October 2017	(10 dose vial)	Yes
HPV	July 2018	(2 dose vial)	Yes

Geographic accessibility

During the rainy season, it is almost impossible to travel by land between Bangui (the capital) and the northeast Prefectures in Health Region no. 5, specifically Vakaga (1,250 km) and Bamingui-Bangoran (675 km), which makes some interventions difficult.

The CAR domestic road network is made up mostly of rural paths that are hard to negotiate during the rainy season and that do not enable access to certain places. Air routes are not well-developed, as the country has less than 20 non-paved airfields, some of which are practically unusable during the rainy season, because of flooding for some and lack of maintenance for others.

Population data by gender and density, by Health Region in 2015

The country's Health Region No. 5 is lightly populated, with a density of 1.2 residents/km^2. Health Region No. 7 (Bangui, the capital city) is the most densely populated, with 12,218 residents/km^2 in 2015.

The 2010 Multiple Indicator Cluster Survey (MICS IV) showed the following, in terms of equity:
At the national level, only 13% of children age 12-23 months had received all antigens.

Table 1 : : Immunization coverage by antigen in children 12-23 months (MICS IV, 2010)

Antigens	Vaccination coverage rate in children 12 to 23 months old
BCG	74%
OPV 3	45%
DTP- HepB- Hib3	32%
MCV	53%
YFV	61%

The analysis of immunization coverage rates by sex and by antigen does not show any significant difference between boys and girls.

Table 2 : DTP-HepB-Hib3 immunization coverage by place of residence (MICS IV 2010)

Place of residence	DTP- HepB- Hib3 immunization coverage
Rural	8%
Urban	23%

There are fewer fully-vaccinated children in rural areas than in urban areas (8%, as compared with 23%). Only two out of 10 children in rural areas have been vaccinated with the three required doses of DTP-HebP-Hib (22.2%), as compared with five out of 10 in urban areas (51%).

Table 3 : BCG immunization coverage by Prefecture (MICS IV 2010)

Zone	BCG immunization coverage <1 year
Bangui	93%
Sangha-Mbaéré	86%
Kémo	84%
Ombella-M'poko	84%
Nana-Grébizi	83%
Mambéré-Kadéi	81%
Nana-Mambéré	80.5%

Accessibility, as measured by the BCG vaccine, shows that the level of first contact with vaccination services for children under one year is good, in seven out of the 17 Prefectures. In the 10 other prefectures, results are fair, varying from 50 to under 80%.

Table 4 : Penta3 immunization coverage by mother's level of education (MICS IV 2010).

Mother's level of education	DTP- HepB- Hib3 immunization coverage
Secondary:	60%
Primary	31%
No education	23%

Six out of ten children (60%) whose mothers have secondary education or higher received the three doses of DTP-HepB-Hib, as compared with three out of ten children (31%) whose mothers completed primary education, and two out of ten children (23%) whose mothers had no education.

Table 5: DTP-HepB-Hib3 immunization coverage by standard of living (MICS IV 2010)

Mother's level of education	DTP- HepB- Hib3 immunization coverage
Poor	21%
Middle	28%
Rich	60%

Only two out of ten (21%) children from poor households received three doses of DTP-HepB-Hib, as compared with approximately three out of ten children living in middle-income housheolds (28%) and nearly six out of ten (60%) from the richest households.[2]

[2] Equity for Immunization in a Crisis Situation : Central African Republic, December 2014

6 Description of the National Health Sector

Background Information

With life expectancy at birth of 47.7 years (RHDP II 2011-2015) and a natural population growth rate of 2.5%, Central African Republic's population is estimated at 4,953,015 residents in 2015 (GPHC 2003). 17.3% of the population is under five years old, and 22.7% is between 5 and 14 years old. This population is largely rural (62%) and is made up mostly of young people (about 49% age less than 18). The gender inequality index is 0.768.

The average poverty rate is 75% (37% in urban areas and 94% in rural areas). The deprivation rate is 59.3 (RHDP II 2011-2015).

Maternal and child health indicators are alarming. Mortality rates for infants and for children under five were 116/1,000 and 164/1,000 in 2010, and the maternal mortality rate was 890 per 100,000 live births (MICS IV 2010).

The military and political disturbances in Central African Republic since 2012 have caused large-scale population displacements, harmed an already fragile economy, increased the fragmentation of the national health system and considerably reduced the functioning of health services as well as public access to them. It is more than likely that health indicators are even worse at present.

Governance and organization of the health system

The health system is organized in a pyramid with three levels: central, intermediate and peripheral.

The central level, the MPH, is responsible for the sector's general policies, regulating the system and national programs such as the five hospitals and four central diagnostic facilities, one of which is private. It includes the Minister's Cabinet, the Cabinet Directorate, three general Directorates and 12 central Directorates that are subdivided into departments and sections.

At the intermediate level, the seven health regions are responsible for monitoring the implementation of policies set by the central level, and for supporting the peripheral (operational). level.

The operational level consists of 30 health districts, which in turn serve other entities (12 prefectures, 10 districts and 8 health areas in Bangui). Health re-districting is planned for 2016, and this should increase the number of districts.

The 2015-2017 cMYP offers an updated description of the institutional organization of vaccination activities. These are coordinated by the EPI Directorate at the central level; it is an integral part of the General Directorate of Public Health within the Ministry of Health and Population. It works at the regional level through a regional EPI supervisor and a regional Focal Point for integrated disease surveillance, and at the Health District level through an EPI coordinator and a Focal Point for integrated disease surveillance. Two entities provide coordination between stakeholders and also direct activities:

- The EPI's Inter-Agency Coordinating Committee (ICC) is the primary entity that manages the activities of the Expanded Program on Immunization, which was created by Ministerial Decree No. 0044 MSPP/CAB/SG/DGSPP/SPEV of 7 Feburary 2002.
- The EPI's Technical Support Committee, created by Decree No. 113 MSPP/CAB/SG/DGSPP/DMPM/SPEV of 11 March 2003. This is a multisectoral and multidisciplinary entity overseen by the General Directorate of Public Health; it supports the ICC's decision-making process.

The past two years of conflict have deeply harmed the system's organization, particularly at the peripheral level. Looting and population displacement have affected health facilities, as well as the regional and district management teams. A HeRAMS survey conducted in 2014 with WHO support gives a clear picture of the level at which health facilities are functioning, and the services that are actually available.

The Health Sector Transition Plan (HSTP) for the Central African Republic 2014-2016 was developed to respond to these new challenges. This was the result of joint work by experts from the Ministry of Public Health (MPH) and all of the country's health partners, during the second half of 2014. It aligns with the Emergency and Sustainable Improvement Program (PURD) prepared by the government, subsequent to the National Health Development Plan (NHDP), which was projected to end in 2015.

The government aims to resolve the crisis by the end of 2016, and to launch a new National Health Development Plan (NHDP III) beginning in 2017. The transition plan seeks to be more dynamic and responsive than a typical NHDP, to better manage the volatility of the situation, and the MPH's high degree of financial and operational dependence on its partners, as well as the necessary coexistence of emergency plans and development plans.

Partnership entities are in the process of adapting to the situation. The role of technical and policy validation has

been officially assigned to the Sectoral HIV/AIDS Health Committee (SHC HIV/AIDS) since 2008, but it needs to be reinvigorated. A Health Sector Coordinating committee (HSCC) is being formed, to allow political entities to benefit from joint strategic recommendations (MPH, TFPs, NGOs) related to the HSTP and its implementation. However this entity will in no way replace their decision-making power.

In terms of vaccination, the Inter-Agency Coordinating Committee provides coordination, in cooperation with the EPI Technical Support Committee. Current activities still use the 2011-2015 cMYP, but a new, updated version is expected before the middle of 2015. This will then lead to a national vaccination plan and a monitoring and evaluation plan, which are still currently unavailable.

Human Resources for Health

The human resources situation is insufficient both in number (see gaps listed in the table below) and in its inequitable geographic distribution in terms of international norms and standards. Human resources are also weak in terms of qualifications, both in technical care areas and in system management.

Table 5: Staffing situation/norms (HSTP 2015-2017)

Job category	Norms	Required staffing	Current staffing	Gap
Physicians, Pharmacists and Dentists	1/10,000	485	267	218
Paramedical Specialists	1/4,000	1,214	327	887
Nurses (Registered and similar)	1/4,000	1,214	1,144	70
Nurses (SFDE/Birth Assistant)	1/4,000	1,214	596	618
Administrative support staff:				
Accounting Manager	1/Hospital/Diagnostic Facility	25	8	17
Civil Engineer	1 National level	5	1	4
IT Engineer/Technician (HR data manager)	1 National level	4	1	3
Maintenance Technician	1/Hospital/Diagnostic Facility	25	2	23
Total		**4,186**	**2,346**	**1,860**

This situation is aggravated by the mass, uncompensated exodus of employees from the Ministry of Health who have been allowed to exercise their retirement rights, and by the departure of some employees subsequent to the socio-political events.
The conflicts led health personnel to flee to the capital; they are underutilized there, but we do not know the exact numbers. In order to redeploy them, we must be able to guarantee acceptable security conditions and practical ways to pay their salaries in rural areas.
In the CAR, the private health sector includes the following entities:

- Private, not-for-profit religions entities (primarily ASSOMESCA) which hire health workers as needed;
- Humanitarian agencies that hire Health Human Resources and send them to areas in which they work;
- Private, for-profit NGOs that hire health professionals, most often those who are waiting for jobs in the public sector or who have already retired.

Infrastructure and services

The HeRAMS survey provides critical information for assessing infrastructure functionality and service capabilities.

The country has a total of 814 health facilities: 674 public, 69 private for-profit, 35 private not-for-profit and 37 religious.

27.7% of these facilities were totally or partially destroyed, with a great disparity between the regions, ranging from 6.8% in HR 2 to 46.1% in HR 3 (both targeted by this proposal).

This, combined with the displacement of staff who fled the conflicts, has affected the functioning of health facilities: only 55.2% of them are considered functional nationwide, with regional disparities ranging from 74.7% in HR 2 to only 24.4% in HR 3.

The Minimum Package of Activities was only recently defined (2010). It has been applied in only some of the front-line health facilities. Clearly, this situation was aggravated by the damage that has happened since the end of

2012. The HeRAMS study shows that only 46.7% of health facilities offer EPI services, and in HR 3, only 17.9% do.

National Health Information System

The NHIS is represented by the NHIS Department, which is overseen by the Directorate of Research and Planning (DRP). It is supported by two committees:

- The NHIS Coordinating Committee, created by Decree No. 120 of 3 December 2010, is the primary entity that manages the NHIS' activities. It is composed of managers from the Department of Health, along with managers from United Nations System partners.
- The NHIS Technical Management committee, created by Decree no. 119 of 3 December 2010 is a multisectoral and multidisciplinary entity that supports the Coordinating Committee's decision-making process.

In practice, the NHIS Coordinating Committee, the NHIS Technical Management Committee and the monthly and annual NHIS data analysis meetings are not functioning. However, EPI coordinating meetings and disease surveillance meetings are held in the health regions and health districts.

Along with this, the NHIS is implemented haphazardly in health facilities; data completion and promptness rates are too low; there is a lack of monthly and annual NHIS data analysis at the central, regional and district levels, which in turn results in a lack of coordination between the National Institute of Statistics and the Ministry of Health, in a lack of integration and coordination between producers and users of health information throughout the country, and in the lack of a permanent system to monitor and evaluation NHIS data. However, at the central level, a monthly EPI data harmonization and epidemic surveillance meeting is held, in order to analyze data, note and correct certain discrepancies and improve the completeness and promptness of reports.

Health sector funding

A. Funding with domestic resources

A1. Government funding

The public health services situation has completely changed in the Central African Republic, due to the political and military troubles. The central government has lost its monopoly on allocating health resources. Only 10% of health spending is funded by the government; the remainder is primarily covered by external aid. In light of the crisis, the government decided in mid-2014 on a policy of free health care for children under five, pregnant and nursing women and emergency care throughout the entire country for one year. It is likely that this will continue throughout the Transition Plan. In practice, free care is dependent on support from external funding, although no studies have been done on this. Other potential funding sources (the public, municipalities, etc.) remain marginal.

A2. Community financing

The community is involved in managing the system through Primary Health Care entities, whose activities are currently hindered by the free care system that the government instituted to respond to urgent public health needs.

Community financing is composed of:

A cost recovery system was established in 1994 in the context of the Bamako Initiative, with consultation rates ranging from 500 CFA francs to 2,000 CFA francs, depending on the health facility's level and the practitioner's qualifications. For the remainder, payment for care at the point of service relies on household contributions (direct payments to care providers), and their ability to pay has been dramatically affected by the crisis.

A participatory approach using community contributions in the form of manual labor, donated materials and direct financial contributions to build health posts and village pharmacies in municipalities exists.

At present, no studies have been done to determine the scope or magnitude of community funding, and even less so for local territorial governments.

No form of risk-sharing or resource-sharing (other than the central government budget) has been implemented in the country.

B. Funding with external resources

On the external level, funding sources come from grants and loans through:

- Multilateral aid: United Nations system agencies, the World Bank, the Global Fund, the European Union, BADEA, BAD, WWF and other humanitarian NGOs.
- Bilateral aid: France, Germany, Japan, China, Egypt, Morocco, etc.

Other sources: Gavi Alliance, the Bill and Melinda Gates Foundation, Rotary International, the CDC Atlanta.

Supply and distribution of vaccines and other inputs

CAR's drug supply chain involves three (3) wholesalers: Centrapharm, the Drug Sales Unit (UCM) and the Pharmaceutical Warehouse Unit (UDP), along with two (2) agents: Shalina and Roffe Pharma, along with religious entities that manage pharmaceutical warehouses. The wholesalers and agents only import drugs that have received Market Authorizations (MAs) for CAR.

The UCM is the national purchasing entity, created after the CFA franc was devalued in January 1994, to allow public access to high-quality drugs at a low cost, and to ensure geographic and financial availability. Unfortunately, the UCM cannot currently fulfill its mandate due to recurring management and operational problems, and to a loss of confidence in foreign suppliers. Nearly all partners in the country prefer to use other suppliers, which results in multiple suppliers of drugs and medical supplies in the country.

The vaccine and consumable procurement system is functional, due to support from partners in the context of the Vaccine Independence Initiative in Africa. Vaccines are ordered through UNICEF. Supply frequency is twice a year at the national level. Vaccines and consumables are distributed from the central level to Health Prefectures once per quarter. Due to logistics deficiencies (lack of delivery trucks and a 4x4 pickup), the distribution schedule is not met.

Vaccine management has been computerized at the central level since 2005 (CAR Inventory Registry files, and DVD MT files), but they are not computerized beyond the central level.

In the Health Prefectures, data management is done primarily on paper. EPI management tools must be revised to accommodate new vaccines.

7 National Health Strategy and Joint Assessment of National Health Strategy (JANS)

For nearly two (2) decades, the Central African Republic has had a series of military and political disturbances. Following the most recent wave of socio-military-political conflicts, the worldwide humanitarian community, including the World Health Organization, classified the CAR at the highest emergency level, "grade 3," as was true of the humanitarian situations in Syria and the Philippines.

To support the government's efforts during this recurring humanitarian crisis, to respond to the most urgent needs of vulnerable groups, to improve community resilience, to create conditions that favor quick economic recovery and long-term peace, the Strategic Poverty Reduction Document II was "used as a guiding light" and an Emergency and Sustainable Improvement Plan (2014-2016) was prepared, in alignment with the Millennium Development Goals.

In addition, the National Health Development Plan (NHDP II), which is projected to end at the end of 2015, no longer fits the emergency context in the country. The country's security situation has made it impossible to perform a JANS-type evaluation of the NHDP II.

To respond to the current crisis, a National Health Sector Transition Plan for 2014-2016 has been prepared and validated. Vaccination is among the high-priority programs, taking into account the problems and challenges related to public health in CAR, due to the EPI's poor performance, "with only 28% of children fully vaccinated with routine immunizations by one year of age, according to data at the end of 2013."

The transition plan was organized around five strategic initiatives:

(1) Improving the Ministry of Health's governance functions;
(2) Making a high-quality Minimum Package of Activities available;
(3) Improving management of maternal and child health, including improved vaccination services;
(4) Improving emergency and disaster management;
(5) Improving disease prevention and treatment.

Improving vaccination is included in strategic initiative 3 of the Transition Plan.

The CAR's Expanded Program on Immunization is inspired by the vision and mission of the Decade of Vaccination, with the goal of reaching universal immunization coverage. It is part of the Regional Strategic Immunization Plan (PSRV) for 2014-2020. The PSRV's objectives are:

- Increasing immunization coverage;
- Ending transmission of the polio virus and confining the virus;
- Eliminating measles and advocating for elimination of rubella and congenital rubella syndrome;
- Achieving and maintaining elimination/control of other vaccine-preventable diseases.

To reach these objectives, the CAR has identified the following high-priority actions:

- Improving the availability and use of immunization services;

- Stopping the transmission of polio virus by the end of 2015;
- Reducing measles-related morbidity and mortality by at least 90%;
- Eliminating neonatal tetanus in the WHO's African region by 2017;
- Introducing new vaccines and new technologies;

Implementing other initiatives that are essential to child survival.

8 Monitoring and Evaluation Plan for the National Health Plan

The Central African Republic does not currently have a monitoring and evaluation plan. Monitoring and evaluation methods are not formalized. In practice, they are often locally influenced by the formats and methods of partners that support these activities, and this affects standardization at the national level.
A chapter in the Transition Plan was devoted to the framework and mechanism for monitoring and evaluation, but the majority of this still needs to be prepared. Thus, the monitoring/evaluation mechanism at all levels of the health pyramid is based on:

- Collecting routine data in the context of the NHIS, but at the moment this does not allow monitoring at every level of the system. This must be strengthened during the transition plan, for the purpose of creating the conditions required to re-launch a complete routine NHIS in the context of the NHDP III. In the meantime, emphasis will be placed on epidemiologic surveillance of diseases, and on re-launching certain key elements of the NHIS. These tools will be customized to the abilities and presence of actors at the decentralized level.
- The supervision and monitoring system was harmed by the displacement of regional and district management team members to Bangui, and the risks related to travel within the country. At first, emphasis will be placed on developing integrated formative supervision formats, which are customized to the abilities of actors at the regional and district levels. As needed, they will be differentiated according to levels of functionality and safety, and the presence of partner organizations (NGOs, TFPs) that can support supervision activities.

Depending on the degree of stabilization and a return to functionality in the health zones, a complete supervision and monitoring system will be progressively reintroduced, with quarterly supervision of activities in the health regions by the central level, supervision of the districts every two months by the health regions, and increased supervision of the health facilities by the district management teams. Initially, the urgent situation is in the health facilities, for the purpose of promoting the reinvigoration of acceptable-quality health services.

In addition to these studies, a midterm implementation evaluation of the transition plan will be scheduled for the second half of 2017 and will be used to redirect the strategies for the second year. A final evaluation will be done in 2018, with the goal of preparing the future NHDP III.

Monitoring and evaluation framework specific to vaccination: Explain how monitoring and evaluation was performed for vaccination activities in the past (2014 reprogramming and earlier) and how it might impact the M&E plan to be included in this proposal.

Midterm and annual reviews for the health sector are performed according to the cooperation plan between the MPH and the UN Agencies. To date, there has been no joint annual review. One is planned for 2016, with support from Gavi in this proposal for training actors who will be responsible for the review.

9 Health Systems Constraints on Achieving Immunization Outcomes

Primary constraints on the health system.

In this section, constraints are presented under general themes that include various dimensions of the health system and issues of access to services. This is the result of a brainstorming session with the proposal writing committee, following the comments from the pre-review in February 2015.

The analytic documentation of the constraints was hindered by the country's lack of resource documents, and the fact that the conflict since the end of 2012 has changed the analysis as compared with prior documents. The Health Sector Transition Plan (HSTP) that was validated in March 2015 summarizes prior documents and includes an up-to-date, shared and approved vision of the current state of the health system. The analysis of high-priority issues and priorities for each component of the 2015-2017 cMYP offers a good example of issues specific to vaccination.

Service offerings are fragmented, and quality is lacking

The first challenge to increasing vaccination coverage relates to the **actual existence of services on the national scale.**

The HeRAMS study includes alarming statistics: of 814 health facilities (including hospitals), only 363 officially included the EPI in their service package in 2014, and 290 of them offered it consistently (HeRAMS). If there is one issue that HSS funding should focus on, it is reducing this gap in terms of quality and quantity. There are serious problems with geographic equity in accessing services; the issue is partially remedied by outreach strategies.

There are multiple causes of this, and they require joint action in various areas of the health system.

- **Package of services** National health standards and the Minimum Package of Activities (MPA) have only recently been defined. Implementing the MPA requires training and logistical support, and the training and supervision methods must be updated; they have been complicated by the crises in the country in recent years. Aside from the failure to integrate the EPI into the MPA, we note deficiencies in the outreach strategies. The cMYP emphasizes the "lack of strategies aimed at populations underserved by vaccination."
- Infrastructure and Equipment Subsequent to the HeRAMS study, the Transition Plan discussed "significant renovation and equipment needs caused by looting and destruction (which also affect the vaccination chain, and specifically the cold chain). *Logistics (vehicles, communication, equipment) are severely inadequate. Potential solutions are limited by security concerns in many contexts.* " (HSTP 2015-2016). Management of the cold chain and procurement/supply logistics has been hindered by recent events, as emphasized in the 2015-2017 cMYP. The updated EVM improvement plan in September 2014 gives a relatively current description of the present situation. Cold chain capacity is sufficient at the central level, but poses problems at the decentralized level, specifically due to the lack of intermediate locations at the regional level for storing vaccines. The country's cold chain is active only in health facilities that were identified as functional in the HeRAMS study; this situation continues to improve as refrigerators are installed and replaced. However, the fuel procurement/supply situation is a problem, due to the lack of service stations inside the country.
- Human Resources The transition plan also notes that, "health facilities (are) understaffed, and most are in Bangui." *This is primarily due to dangerous conditions, a lack of decentralization and non-payment of salaries.* For the MPA/CPA, qualified staff are severely lacking in many health facilities." (HSTP 2015-2016). We still do not have a Human Resources head count to document the problem, but it is widely agreed-upon by sector stakeholders.
- Procurement Problems with procuring and shipping drugs are discussed in a general way in the HSTP, and they have led most TFPs and NGOs to create their own procurement/delivery chains. The EPI has largely escaped these problems with procuring vaccines and inputs, as UNICEF has primarily handled this for years. NGOs own systems have been in place since 2013. UNICEF also procures fuel. But at present, the decentralized levels are not able to come get their vaccines as they used to do, because their vehicles were looted. The country only has one functioning refrigerated truck (used to transport vaccines from the airport to the cold room) and two trucks are broken down.

Issues with mobilizing financial resources

As stated in the 2015-2016 HSTP concerning the entire health system, "sector funding (is) highly dependent on international partners. The central government's contribution represents approximately 10% of total health

spending." (HSTP 2015-2016) This also applies to vaccination-related issues, as the central government is focusing its meager resources on managing the crisis, and TFPs and NGOs tend to focus their support on the most critical emergencies in the areas in which they work.

The Gavi-HSS involvement must complement existing involvement and funding. At this stage, it is difficult to get a clear picture of how this works, because there is no detailed map of what partners are doing, and where. However the context is favorable, due to efforts to improve cooperation and coordination between actors, initiated by the 2015-2016 HSTP, and due to the ongoing creation of the Health Sector Coordinating Committee (HSCC).

The central government's financial contribution to the health sector represents, on average, 9% of the overall budget. This is less than the goal set in Abuja (15%).

In 2014, the amount allocated by the central government to the Expanded Program on Immunization was CFA Fr 781,929,165; to be completed (see cMYP budget analysis).

Poor quality and use of data

In general, the HSTP notes that, "the NHIS data are unreliable, due to a low completion and promptness rate, and due to insufficient skills at all levels." (HSTP 2015-2016). The external review of the EPI and the 2012 vaccination coverage survey confirmed this, as applicable to vaccination. In addition, the HSTP later specifies that, "the epidemiologic alert system must be immediately reactivated." (HSTP 2015-2016). This will directly impact all vaccination-related activities.

There are multiple causes, related to training and staff availability gaps, lack of supervision and poorly skilled local focal points, all of which have been aggravated during the past few years by the population and staff displacements.

The data are considered unreliable and are not sufficiently used for decision-making at any level of the health system whatsoever.

In addition, since 2013, many NGOs have included vaccination activities in their activities, but there are problems with information-sharing due to poor-quality methods of vaccination data reporting.

The HSTP does not recommend that a full NHIS be re-launched. Instead, it proposes that "emphasis (be) placed on epidemiologic disease surveillance and on re-launching some key elements of the NHIS." (HSTP 2015-2016). The reasons for this are simple: the country does not currently have the training or the staff to run a complete information department, so we should focus on critical tasks at first. This should be specifically noted in the Gavi-HSS proposal.

Coordination and governance issues at the central and peripheral levels.

"The need to improve strategic coordination and cooperation between the MPH, TFPs and NGOs at the central and decentralized levels," is described as the first HSTP challenge related to the health system (HSTP 2015-2016). "Expertise and analysis must be transferred if we want the health system and the Central African Republic population to benefit from the lessons learned from partners' work in the country, and if we want to effectively replace emergency interventions with development work. "

Through the ICC and the EPI Technical Support Committee, vaccination has fairly functional entities supporting it, as seen by the attached meeting minutes. However, the cMYP draft shows weaknesses in terms of coordination and capacities at all levels. In practice, many agencies are conducting vaccination activities, but there is insufficient coordination with the Ministry of Health. This may be due to urgent needs, but it also risks disrupting national coordination of vaccination programs. There is no specific documentation on this, but there are different targets (in terms of age ranges), project specifications (issued by the organizations' head offices), reporting and information-gathering formats, and different ways of including vaccination in health services in general.

Therefore, the central coordination role must be improved. A major opportunity lies in putting the coordination entities in contact with the Health Sector Coordinating Committee (HSCC) which was created under the HSTP 2015-2016. This involves creating a joint vision shared by the MPH, TFPs and NGOs, which would allow for a cooperative approach while maintaining a critical and constructive outlook on each entity's work.

The 2015-2016 HSTP also specifies that, "the Ministry's presence (is) insufficient at the decentralized level (region, and particularly district). This hinders the MPH's ability to exercise its governance (regulation, planning, supervision, training) and coordination role with partners working in the country. " (HSTP 2015-2016).

In practice, we also see that at the district and regional level, the size and quality of teams vary, and they are often insufficient, due to "poor technical, managerial and programmatic capacities," (effective vaccine management, supervision, planning, etc.), "poor program coordination" (cMYP 2015-17, section 4.4) and frequent absences due to other programs.

Monitoring of routine vaccination activities remains poor, and primarily depends on visits organized through the central level, and where regional and district teams may or may not be involved. Frequency is insufficient, due to

schedule conflicts and lack of vehicles.

Problems difficult to solve through Gavi intervention

- Accessibility problems related to security in some parts of the country.
- Structural problems outside the MPH's control in some areas of the country, such as the lack of a banking system at the peripheral level and difficulties in sending payments (specifically salaries) or the lack of service stations to buy fuel.

10 Lessons learned and experiences noted

There is little documentation on the lessons learned from these experiences. There are few studies or writings on the CAR's health sector. Reviews and documents from the past few years have definitely provided useful information, but it must be balanced with the transformations that the system has undergone over time; there is little documentation on this. The HeRAMS study is a major contribution. Other past evaluations or policy documents have been used to the extent possible (2011 EVM evaluation and the related improvement plans and implementation reports; the 2012 external EPI review; the draft of the 2015 EPI action plan which is being finalized; the 2011-2015 cMYP and the 2015-2017 cMYP which is being finalized; the 2014 Gavi-HSS reprogramming; the 2013 and 2014 Joint Report Forms (JRF). However, most of the lessons described below are the result of observations that are widely shared but are not formalized in a document.

Objective	Lessons learned that highlight successes as well as difficulties; include all lessons learned from implementing a grant.
Objective 1: Strengthen governance and coordination of vaccination activities at the central, regional and peripheral levels.	**Current consensus on strategies** The MPH and its partners reached a consensus on the 2015-2016 HSTP, establishing joint strategic priorities that are adapted to the current crisis situation, despite initial disagreement on the different intervention ideas and strategies (ministerial, emergency, development). This dynamic should be used to the benefit of vaccination activities. **Past coordination difficulties** The Sectoral HIV/AIDS Health Committee created in 2008 is the only policy validation entity, but it meets rarely, has little documentation and needs to be reinvigorated. The 2012 external EPI review lamented the lack of a coordination entity at the peripheral level, while acknowledging that the ICC and the EPI Technical Support Committee work well at the central level. Since the end of 2013, the Health Cluster has brought operational partners together every week, to discuss emergency issues; they have struggled to make progress on strategic coordination issues. But this issue is essential (see next point). The involvement of primary health care coordinating committees has been limited to two prefecture committees of the seven prefectures in which the project works. Current coordinating problems with humanitarian actors active in vaccination at the central and decentralized levels. Humanitarian action required emergency

	responses outside the national planning schemas. With no documentation, this has created frequent frustration on all sides, and has led to a lack of efficiency (different targets and intervention areas, traceability issues, impact evaluation issues, difficulty estimating available funding and operational and financial gaps, etc.) Flexibility in the customized approach Gavi's customized approach has been critical in responding to context-specific problems in the past. Specifically; Extension of the age bracket to 23 months for all antigens during Intensified Vaccination Activities (IVA) improved vaccination coverage in 2014 and created herd immunity in the target populations; funding for contract employees' salaries made it possible to hire staff and improve health center functionality. **Centralization and weaknesses of Region and District Management Teams** The displacement of many management team staff members and the centralization of governance functions are seen as having harmed the pertinence of scheduling and supervision. This is also a major difficulty for NGOs working in the country; they are struggling to find and mobilize MPH representation at the decentralized level.
Objective 2: Ensure the conditions and quality of curative and preventive health care and health promotion activities, in compliance with the Minimum and Complementary Packages of Activity, including vaccination in health regions 1, 2 and 3.	**Major construction and renovation needs** As stated in the HeRAMS study, the conflict that has been ongoing since 2013 has resulted in the looting and destruction of 27.7% of the country's health facilities, leaving only 55.2% of health facilities with an acceptable level of operations. Regions 1 and 2 have been relatively unharmed as compared to the rest of the country. However HR 3 has been particularly hard-hit, with 46.1% of health facilities being damaged. The need to renovate health facilities is also on the agenda for the government's Emergency and Sustainable Improvement Program (PURD). However, 48 damaged health facilities have been renovated and rendered functional with support from NGOs and financing from the Humanitarian Emergency Fund in 2014. This support, based on free care directives, has improved access to health services, including vaccination, in the affected areas. **Lack of staff: quantity, quality and inequitable distribution** The conflicts resulted in numerous staff leaving their positions and moving to the capital. Due to the lack of a staff chart, this phenomenon is not yet documented but this observation is widely shared. This has dramatically constrained services in the past, and has resulted in a smaller number of facilities and of staff who can provide services. In terms of vaccination, this has specifically resulted in a focus on EPI centers rather than including the EPI in health centers or health posts (see below). **Under reprogramming, 45 qualified health staff have been hired and assigned to health facilities in the project zone. This has improved the quality of health service offerings in general, and the EPI in particular.** In addition to staff retirements and deaths, the Department of Health plans to hire 650 health workers for public services. **Insufficient coverage of health services offering vaccination services (EPI not integrated into the MPA).** The HeRAMS study shows that only 46.7% of health facilities include the EPI nationwide, and this percentage falls to 17.9% in HR3. These numbers are comparable to those from the 2012 external review of the EPI (before the current crisis), which stated that only 45% of health facilities provided vaccination services. The 2015-2017 cMYP is being finalized. It states that only 290 of the 365 health facilities that offer the EPI were effectively carrying out vaccination activities before the crisis. The vaccination service deficit is explained by the **delayed preparation of health standards** and Minimum Packages of Activity (2011), which are still irregularly applied on the national level. The results-based financing approach motivated some health facilities to include vaccination in their MPAs, which thus increased the number of EPI centers. **Disparate implementation of the service package** The HeRAMS study also includes a map of available services by region, which shows a great disparity in the offerings in different regions. Regions 1 and 2 show a much less dramatic profile than the country's eastern regions, but they are still extremely concerning. However region 3 is largely in the red.

	Importance of an integrated approach The inclusion of activities that have a high impact on child survival and development (deworming, vitamin A supplementation, iron and folic acid for pregnant women, LLITNs) were very positively received by the teams responsible for vaccination at the central level; they also motivated the current desire for an integrated approach. This is specifically evident from this proposal's focus on including vaccination in the MPA. **Success of Intensive Vaccination Activities** Recent collaboration between the MPH and NGOs active in the country resulted in innovative approaches and strategies and a constant increase in vaccination coverage (ex: Penta3 increased from 28% in 2013 to 45% in 2014). This emphasizes the need for creativity in the face of the damage to the system and population migration, and the importance of strategic and operational collaboration with NGOs. **Poor vaccine management** The 2011 EVM evaluation painted a worrisome picture of vaccine management in the CAR, with overall performance of around 60% at the central, prefecture and health facility levels. The situation has clearly deteriorated since then, specifically concerning the cold chain, management capabilities at the decentralized level (due to human resource deficiencies) and logistical capabilities for procurement. This observation was confirmed by the draft of the EPI's 2015 action plan, which lamented the shortages of vaccines and other inputs in many health facilities.
Objective 3: Improve the quality and use of health information for epidemiologic surveillance and the EPI.	Large-scale studies and documentation. In the past, the country has succeeded in performing high-quality studies, specifically the 1995-1996 DHS. The SURVAC project to improve epidemiologic surveillance in Central Africa also tested the country's ability to use the integrated management system. Aside from the results of the HeRAMS study, the level of documentation and evidence is very low. Deficiencies in reporting vaccination data The 2012 external EPI review (pre-crisis) had already expressed serious concerns about reporting (ex: only 20% of health centers correctly reported data). The crisis certainly did not improve these numbers. This led to a desire to temporarily refocus the health information system on a limited number of indicators which can be managed by local actors and which will enable proper orientation of decision-making. Difference in formats/tools for collecting and reporting data between organizations The involvement of other actors who use data collection tools in different formats than those used at the national level has made it impossible to obtain reliable data. This has made it impossible to have an overall vision, and has cast doubts on the completeness of the information. Standard data reporting formats are needed in the future. Exercises to standardize the surveillance and EPI databases, as well as the DQS missions in 2014 and 2015 by the MPH, the IPB, UNICEF and the WHO improved data quality. This cooperation framework should be expanded to the peripheral level. Consequences of poor reporting Intensified vaccination activities and implementation of the Reach Every District strategy allowed the CAR to significantly improve immunization coverage from 2006 to 2007. Due to certain deficiencies in data completeness which harmed the quality of vaccination data (children were vaccinated and included in the vaccination registers as having been vaccinated, without including them by name in the routine EPI's vaccination registers), Gavi's support was temporarily suspended. The EPI national teams remember this as a lesson on the importance of data quality for mobilizing and sustaining donor funding. **Current deficiencies in the national health information system** Although no document summarizes this, it is widely acknowledged that the information system suffers from low completion and promptness rates, which have been aggravated by the crisis. The small amount of information produced has been compiled, but has not been approved since 2012, and has not been used for decision-making.

PART D – PROPOSAL DETAILS

11 Objectives of the Proposal

The proposal is closely aligned with the HSTP 2015-2016, not only in terms of vaccination activities themselves, but also by including the specifics of the HSTP 2015-2016, as compared with the previous national plans (joint vision and coordination with NGOs and TPFs to surmount the current crisis, focus on governance and re-launch operations, differentiate norms and packages according to local operational conditions, re-launch an information system adapted to capabilities and essential needs, etc.).

The current proposal aligns with the 2016-2017 cMYP that is being finalized. However it clearly includes, without actually citing, the major HSS objectives in the current document as well as those in the draft of the 2015 EPI Action Plan (improve planning, improve service offerings, include vaccination in MPAs, improve capacities at various levels, support monitoring, storage and cold chain, transportation, supportive supervision, employee motivation).

The proposal is part of the continuation of the 2014-2015 emergency reprogramming and seeks to maintain support for key activities, with the obvious exception of spending that has already occurred.

Finally, it aims to complete the other work planned for the central and decentralized levels, specifically institutional support procured via the Beku multi-donor fund which is active in the three intervention areas.

The intervention will focus on the central level and on Health Regions 1, 2 and 3, which are also areas in which the 2014-2015 reprogramming focused. This is a pragmatic decision, in light of safety, accessibility and population density criteria. We hope to have the greatest impact in these dense regions, in terms of increasing the country's overall vaccination coverage. This is also a response to concerns about geographic equity, with the inclusion of region 3, which shows particularly alarming indicators in terms of functionality and delivering services, as compared with the rest of the country (see HeRAMS study). There might have been the possibility of focusing programming on zones in the eastern half of the country, but this would have involved the risk of hazardous working conditions aimed at dispersed and nomadic populations requiring costly strategies, and due to the significant difficulties in finding enough staff and collaborating with partners and the public. As clarified in section 5, there are no particular gender equity concerns. The other dimensions (ex: socio-economic equity) are naturally taken into account due to the population's overall state of poverty and vulnerability.

In practice, this includes: a management team at the central level; three Regional Management Teams; 10 District Management Teams; 380 health facilities (including 80% of health facilities in the target zones) across the 10 districts. Note that the number of District Management Teams receiving support should increase from 10 to 19 after health redistricting, with expected Gavi HSS funding for infrastructure, support, training and accompaniment.

Objective 1: Strengthen governance and coordination of vaccination activities at the central, regional and peripheral levels.

Objective 1 aligns with the first expected result of the HSTP 2015-2016 in terms of institutional strengthening and restoring governance functions.

It covers **strategic cooperation between the MPH and partners** on issues of vaccination at the central and peripheral levels, within the Inter-Agency Coordinating Committee. This aligns with the work on strategic recommendations for implementing the HSTP, made by the Health Sector Coordinating Committee. A specific theme group on vaccination will be created, with 5-6 technical experts from the MPH and partners, to prepare the ICC and HSTP's work.

It is also intended to re-establish technical and material capabilities for training and supervision at the regional and district levels through **strengthening the management teams** for HS 1, 2 and 3. This will add to the work of the Bêkou multi-donor fund in selected District Management Teams, as well as the support of certain NGOs. Particular emphasis will be placed on HS3, which has the most concerning indicators for treatment and services. This support will impact all health activities at the decentralized level, with a particular focus on vaccination.

It will pursue the objectives of **strengthening community participation and multi-sectoral collaboration,** which were already initiated under the 2014-2015 reprogramming.

Finally, it includes an important **monitoring and documentation component to support decision-making** through improved supervision capabilities, funding for studies, technical assistance and audits. It also lists the evaluations required for the program and for the preparation of future bids. This aligns with the 2015-2016 HSTP's aim of preparing for the end of the crisis and the development of the NHDP III in the future.

Objective 2: Ensure the conditions and quality of curative and preventive health care and health promotion activities, in compliance with the Minimum and Complementary Packages of Activity, including vaccination in health regions 1, 2 and 3.

Result 2 of the 2015-2016 HSTP and numerous components of the cMYP emphasize the need for integrated strengthening of the service offer via interventions in various areas to strengthen the health system.

Objective 2 aligns with this. In general, it aims to create conditions under which **a complete minimum package of activities can be re-launched** in the health facilities in HR 1, 2 and 3 with particular emphasis on issues of vaccination targeted at children. Expanding and standardizing the MPA at the primary level is an important challenge. This goes along with the effective implementation of the RED approach and all of its components; the country has recently had positive experiences with this. **Community components** will also be included, specifically the search for vaccination dropouts.

Given the recent damage, objective 2 includes a significant logistics component, without which vaccination activities are impossible. This also involves the country's preparation for the future withdrawal of NGOs and TFPs which still play a key role in vaccination and other health activities. This involves **renovating health centers** and providing associated support, reinstating **cold chain** capabilities from the central level to the public, and strengthening **technical procurement methods.**

Human resources are supported via **capacity-building programs** (depending on the requirements of the MPA and vaccination strategies), and methods for **financial and non-financial motivation**. Note that some components depend on external factors. This specifically relates to the government's ability to redeploy staff to peripheral areas, in a context where a significant percentage of these employees had abandoned these zones due to security issues and practical difficulties.

Objective 3: Improve the quality and use of health information for epidemiologic surveillance and the EPI.

The HSTP does not include specific results or intervention areas related to a national NHIS program. However, the 2015-2016 HSTP emphasizes "improved production and use of information" in its first result. This is part of a strategy. Many health facilities are understaffed, both in terms of quality and quantity. For the system's re-launch, it is preferable for staff to focus on producing essential information rather than becoming bogged down in the requirements of the NHIS and completing them poorly.

The HSTP emphasizes epidemiologic surveillance, which will be expanded to the EPI under this proposal.

The program will support the **development of health information formats** adapted to local capabilities and essential needs, ranging from a basic package (epidemiologic surveillance and vaccination data) to a complete NHIS. The associated **training tools and modules** will be supported, with the aim of producing basic information on the national scale that is required for decision-making, specifically in the area of epidemiologic surveillance and vaccination.

This also requires **improving and maintaining the IT systems** at the central level and in the three regions involved in the intervention.

In addition, the program will support all other activities that are required to **guarantee quality and stimulate the use of the information collected**, including at the decentralized level, specifically via support for monitoring, data harmonization meetings and microplanning activities at the decentralized level.

Objective 4: Program management

This is a generic objective: it provides a more precise of [sic] the program support activities. The primary activities relate to program administration.

It is important to distinguish between institutional strengthening, which is an integral part of strengthening the health system, and the administration of the Gavi HSS program.

This objective should have included tasks related to managing the contract award system. In reality, it proved cumbersome from the organizational standpoint: more human resources, more office support, additional bonuses for commission transfers, etc. In this context and in compliance with the spirit of the Paris declaration on development aid, the writing team decided to leave this issue to the existing national system. However, this approach will require that an accompaniment plan and national resources (co-financing) be put in place, to avoid contract awards becoming a constraint for the project.

12 Description of Activities		
Objective / Activity	**Task (budget)[3]**	**Explanation of link to improving immunisation outcomes**
Objective 1: Strengthen governance and coordination of vaccination activities at the central, regional and peripheral levels.		
1.1 Provide operational means for a Project Management Unit for the program.	1.1. Develop a tool specific to the national context for processing health information at all levels. 1.2. Prepare a manual detailing all aspects of administrative, financial and accounting management related to the Gavi-HSS project. 1.20. Implement visibility tools.	This activity includes developing a tool specific to the national context for processing health information at all levels of the pyramid, and preparing a manual detailing all aspects of administrative, financial and accounting management related to the Gavi-HSS project as well as Internet service fees.
1.2 Support strategic cooperation entities between the various actors at the central and peripheral levels.	1.3. Provide coordination (ICC meetings at the central level). 1.4. Organize technical group meetings (UNICEF, WHO and EPI) of the EPI Technical Support Committee at the central level. 1.5. Support meetings of the prefecture committees of the primary health care services to validate data or documents prepared at the decentralized level.	Vaccination activities require intense coordination, in light of the co-existence of the various actors (MPH, TFPs, NGOs). The program will support the activities of the ICC and the EPI Technical Support Committee. The creation of the HSCC and the associated thematic groups in the HSTP, as well as the existence of the Health Cluster offer an opportunity that should be seized; an opportunity for an integrated HSS approach centered around a complete MPA. In practice, smaller technical groups (UNICEF, WHO and EPI) are already meeting, to facilitate the decisions of the EPI Technical Support Committee and the ICC. This serves as a thematic group for vaccination, as specified in the context of the HSCC. At the peripheral level, these activities go along with supporting the strengthening of the region and district management teams. The challenge is specifically to ensure implementation of activities on a quarterly basis, in collaboration with the NGOs present on site, including vaccination activities (scheduling, targets, reporting, other). Support for the prefecture primary health care committees is also planned, to strengthen the involvement of administrative authorities in directing public health activities.
1.3 Strengthening region and district management teams' governance role at the decentralized level.	1.6. Support operations of the 5 district management teams/10.	This involves recreating conditions that favor coordination at the decentralized level, for better monitoring of health activities and coordination with partners present on site. The Ministry of Health is responsible for redeploying employees. It is expected that complete teams will be in place after 12 months of activity, and will progressively take over the supervision activities that the central level currently performs. This includes an operating budget for the district management teams (office supplies, consumables, IT maintenance and bank fees) as well as a budget for capacity-building for three years, in the areas of training, supervision and planning.
1.4 Renovating and equipping health administration facilities at the regional and district levels.	1.21. Renovating administrative facilities at the operational level.	All regional and district management teams have been looted. This line item focuses on renovating buildings and furniture for the five health administration facilities, not including IT equipment and

[3] Task numbers correspond to the activity numbers in the Excel budget tool

		vehicles (included in other line items) in year 3.
1.5 Providing the central, regional and district levels with the vehicles required for training and supervision activities.	1.7. Purchase vehicles for the health districts. 1.8. Purchase motorcycles for the health facilities. 1.9. Purchase bicycles for the health facilities. 1.17. Provide maintenance for motorcycles. 1.18. Insure the motorcycles purchased in the context of the project.	This involves providing training entities with basic material means for completing supervision visits at the regional, district and health facility levels, in addition to recent support (reprogramming) and current support (Bêkou funds). Through the Health Systems Strengthening project, the European Union plans to purchase vehicles for the regions and districts. The 2014-2015 reprogramming has already funded three vehicles at the central level and five motorcycles for the district management team (not to mention the eight that were purchased in 2012 using funds from the ongoing proposal, before funding was suspended). The current program will provide 55 additional motorcycles in year 1, and operating funds for the remainder of the districts' motorcycles (new motorcycles + 13 motorcycles including five purchased under the reprogramming). The health facilities will be provided with 187 bicycles to complete the items provide to 194 EPI centers in the context of reprogramming.
1.6 Promoting community participation and multi-sector collaboration.	1.10. Reinvigorating actors' cooperation entities (primary health care entities) at the intermediate levels (3) and peripheral levels (10). 1.11. Reinvigorating actors' cooperation entities (primary health care entities) at the central level. 1.12. Reinvigorating the work of the Management Committees and the Primary Health Care Committees at the national level.	The activity is part of the continuation of the 2014-2015 emergency reprogramming. It aims to recreate conditions that promote relationships between the health facilities and the public, which have been harmed by the current crisis and population displacements. It specifically involves re-launching the Primary Health Care entities, providing ongoing support to renew the management committees, and providing support to the Management Committees (COGES), including training programs.
1.7 Supporting microplanning activities in the Health Districts/ Health Prefectures (mapping and counting the areas served by the health facilities).	1.13. Preparing a MPA/CPA map by intervention zone (health areas covered by the health facilities in the 10 Health Districts). 1.14. Supporting the Health Districts in preparing integrated annual plans and monthly work plans. 1.19. Preparing Annual Work Plans in the target regions.	The goal is to ensure proper management of the health areas and vaccination areas for each level of the health system. The activity is part of the continuation of the 2014-2015 emergency reprogramming.
1.8 Organize an EVM evaluation. .	1.15. Cover costs for national and international experts to complete an evaluation of the EVM. 1.16. Organize a presentation and discussion meeting, and validation of the results of the EVM evaluation.	This activity will help improve the quality of vaccine management, along with other studies that will be completed on funding from other partners, specifically: Conduct an EVM assessment in 2018. The most recent evaluation was in 2011, updated in 2012. A new EVM is planned in the context of reprogramming. JANS and SARA, funded by the WHO. MICS V survey including a vaccination coverage survey in 2016, given that the last MICS IV was in 2010, funded by UNICEF. National Health Accounting (most recent: 2010), Demographic and Health Survey (most recent: 1994).

Objective 2: Ensure conditions and quality of curative, preventive and promotional services offered in accordance with the minimum package of activities in regions 1, 2 and 3		
2.1. Proceed with renovating and equipping of priority health facilities.	2.1. Renovating and equipping health facilities 2.2. Equipping health facilities 2.3. Installing water sources in the health facilities	The objective is to efficiently proceed with renovating/equipping the priority health outposts selected, to enable the existence of curative, preventive and promotional services and to increase accessibility. The GAVI-HSS grant will focus on renovating and equipping the health facilities identified during the HeRAMS survey

		for health regions 1, 2 and 3: 13 HCs have been selected.
2.2. Re-establish and maintain the cold chain at the central level and the three targeted regions.	2.4. Procure solar refrigerators 2.5. Ensure cold chain maintenance at central level 2.6. Ensure cold chain maintenance at operational level	An efficient cold chain is required to deliver immunization services. Here as well, pillaging significantly decreased capacity at numerous health facilities at both the regional and district levels. This fact was taken into account for the 2014-15 reprogramming, followed and completed within this application. This will also be the opportunity to proceed with solar refrigerators that comply with WHO recommendations, along with the 190 solar refrigerators which have already been provided in the targeted regions during reprogramming. The budget line item includes: maintenance (curative and preventive) for the cold chain and generators at the central level; regular provision of fuel for the central level generators; provision of 78 solar refrigerators, coolers, vaccine carriers; regular supplies to be provisioned over a three-year period (burner, wick, glass, gas, etc. kit) for the gas-powered refrigerators that have not been changed out. Study about the creation / renovation of regional essential medicins supply centers in the three regions, including a cold room for vaccines.
2.3. Revise directives and standards related to immunization	2.7. Revise directives and standards related to immunization 2.14. Develop MPA/CPA standards and procedures	The goal is to revise existing directives and standards while taking the introduction of new vaccines into account. Support and skills strengthening programs will be developed as needed. Different levels of MPA development will be considered, in compliance with the principle of the differentiated approach supported in the HSTP (adapting operations and security for local levels). This includes consulting to determine appropriate standards and procedures and developing guidelines; the production and distribution of the guidelines; training for all districts and health facilities on the essential elements of immunization (cold chain, storage, immunization administration); the integration of standards and procedures into integrated supportive supervision formats.
2.4. Provide the central, district and health facility levels with the means of transport needed to transport vaccines, inputs.	2.8. Procure trucks for medicine transport 2.9. Ensure the supply of fuel for trucks that transport medicine 2.10. Ensure the maintenance of fuel for trucks that transport medicine 2.17. Procure trucks medicine transport	Due to pillaging, all means of transport have disappeared, very seriously complicating the supply of inputs and negatively affecting the ability to provide training and monitoring, and also negatively affecting activities for mobilizing the population. The program will provide the various levels with means of transport and the related costs of operation, in addition to the earlier support provided, including: two trucks at the central level with which the central level can supply the regional levels.
2.5. Implement incentive and loyalty measures for the regions and districts as well as for the workers in charge of immunization	2.11. Implement incentive and loyalty measures for the regions and districts as well as for the workers in charge of immunization	This is a continuation of the bonus mechanisms supported in reprogramming. The goal is to encourage the health workers and executive teams to attain good results in essential MPA areas, including immunization. This includes two sub-activities: Continuity of funding for staff bonuses; Consulting and studies related to the bonus mechanism outcomes and adapting the model in year 3, to plan for the future evolution of funding. This second sub-activity has been integrated into the studies that are to be conducted within the context of human resources development
2.6. Recruitment of 45 qualified	2.12. Recruitment of 45 qualified health workers to	This activity was already included in the

health workers to be under contract for the health facilities and the HD/outposts receiving support	be under contract for the health facilities and the HD/outposts receiving support	reprogramming and is being extended within the context of this customized approach, benefiting CAR by making qualified health workers available to provide quality health services, including immunization.
2.7. Support implementation of outreach and mobile strategies in the 10 targeted districts	2.13. Organize outreach strategies	In the current context which is characterized by displacement of the population and difficult access to functioning health services, these itinerant strategies will allow for immunization coverage to be improved, in cooperation with the NGOs.
2.8. Strengthen the search for dropouts, using community health workers	2.15. Compensate 300 community health workers	In the budget, this activity has been integrated into the missions assigned to the community health workers and the CSOs so that they are able to participate in the national integration strategy for community action. This activity is already supported within the context of reprogramming and is important for bringing children back to the immunization programs. It has two main components: additional training for the health workers who were not previously trained; deposit of community health worker incentives.
2.9. Develop partnerships with CSOs related to community health activities, including immunization	2.16. Provide compensation for community health workers 2.17. Develop partnerships with CSOs that are related to community health activities, including immunization	- integrated management of childhood illness (community IMCI) in addition to support from other partners (example: EU in Bossangoa and Bouar) - Promotion of Essential Family Practices (EFP) - communication / raising awareness about routine immunization - participation in mobilizing for mass immunization campaigns National Community Health Strategy to be developed within the context of the EU project.
Objective 3: Strengthen the quality and use of health-related information for epidemiological surveillance and EPI		
3.1. Strengthen and maintain the network of computers at the central, regional and district levels and ensure computer maintenance	3.1. Procure computer equipment (for the NHIS) 3.2. Provide facilities at the central and decentralized levels with virus protection software and computer maintenance	This activity will enable the central, regional and district levels to have data management equipment. The central level and the three regions were provided with this type of support during the 2014-15 reprogramming. Today, this support is being extended to the districts and, therefore, includes: the purchase of 10 computer kits in year 1 and year 5 and in year 2 if the health districts are redrawn; 10 preventive replacement kits in year 3; the costs of software and computer maintenance for the entire network of computers for the duration of the program.
3.2. Develop health information tools appropriate for local use.	3.3. Develop health information tools that are appropriate for local use.	Health information is currently only partial and fragmented. The NHIS has not been applied in a uniform manner throughout the entire country and there are different formats used being used by the NGOs and the TFPs. The 2015-2016 HSTP identified epidemiological surveillance as a leading priority as far as health-related information in concerned. It is understood that the information packet should be more in-depth in the zones that have the capacity to document it. Region 1 already has a fully functional NHIS, region 2 has a partially functional NHIS and region 3 has no information system. In the three regions, completeness and timeliness rates require significant improvement. The GAVI-HSS program is going to take the lead for this activity and coordinate the relaunch of the various information system packets with

		all the partners, ranging from minimum requirements for epidemiological surveillance and a fully functional NHIS for the EPI. This will specifically require: consulting and workshop costs; creating collection tools and guidelines, including computer tools; training trainers to use tools at the different levels within the system; providing telephone communication tools to the health information system focal points to improve data collection, transmission and timeliness.
3.3. Provide training for those participating in health care (MPH, partners, communities) on the use of information system management tools	3.4. Train staff to use the NHIS tools	All participants in the health system need increased capacity, due to the deficiencies in the previous system and the changes and priorities called out in the 2015-2016 HSTP. The objective is to provide a minimum information baseline on epidemiological surveillance and EPI, extending it to other areas, as local capacity allows. This involves: document distribution (registry, management cards, monitoring cards, facility report cards, etc.); local training programs on data production and use for reporting and local decision making; integration with the formative supervision programs.
3.4. Support districts with intervention monitoring at the health facilities, districts and prefectures (DQS)	3.5. Support districts with intervention monitoring at the health facilities, districts and prefectures (DQS)	Conduct data quality audits for the immunization system and for data completeness, while monitoring the consistency of data from various sources (immunization registry, data facility report cards, immunization tally records and immunization cards). The activity is a continuation of the 2014-2015 reprogramming and involves funding for retraining and training of the district management team members on DQS methodology. Monitoring activities such as these are integrated into the formative supervision supportive program.
3.5. Develop and produce the health statistics yearbook	3.7. Provide mission costs for international expertise for the yearly development of the health statistics yearbook 3.8. Produce the health statistics yearbook 3.9. Organize the validation meeting for health statistics yearbook data	The last complete health statistics yearbook dates from 2008. Since that time, data has been compiled electronically but has not been validated and published. The program will support production of a new yearbook, appropriate for the type of information collected (minimum requirement for epidemiological surveillance and EPI). Certain standard information will be collected at the national level, and other information (complete NHIS) is only relevant to certain regions, which will be clearly designated.
Objective 4: Program management		
4.1. Provide full-time salary for the Management Division accountant	4.1. Provide full-time compensation for the Management Division accountant	The Coordination Division within the Ministry of Health will be responsible for coordinating and monitoring all activities. With regards to the previous application, the need to finance the salary of a full-time accountant as well as an administrator was identified and discussed with GAVI.
4.2. Implement incentive and loyalty mechanisms for the position: per diems and communication costs for the management team at the central level	4.2. Implement incentive and loyalty mechanisms for the position: per diems and communication costs for the management team at the central level	The activity includes the payment of per diems for the management team at the central level.
4.3. Provide for Management Division	4.3. Provide communication costs (via telephone credits) for Management Division	The activity includes the cost of telephone communication, support operations for the

operations at the central level and at the three HRs	4.4. Provide central level and three HRs' Management Division with office supply kits.	central support structure and the three HRs (office supplies, supplies, computer maintenance and bank fees, etc.).
	4.5. Procure office equipment: binding machines + photocopiers	
4.4. Provide activity monitoring in the field by the central level Management Division and that of the decentralized levels	4.6. Provide fuel for vehicles acquired within the context of the project (central level)	The activity includes operational costs (fuel, insurance, maintenance) for the vehicles provided to the central level as part of the reprogramming as well as to the decentralized levels, within the context of the current application as well as other funding, 17 vehicles total.
	4.7. Provide fuel for vehicles acquired within the context of the project (regional and district levels)	
	4.8. Provide maintenance for vehicles acquired within the context of the project	
	4.9. Provide vehicles acquired within the context of this project	
4.4. Provide program oversight	4.10. Organize oversight missions in the districts receiving support (team of 03 inspectors, in compliance with the rules in force in CAR)	
	4.11. Conduct an internal audit of the program accounts	
	4.12. Conduct an external audit of the program accounts	
	4.13. Provide mission costs for international expertise for mid-project and end-project evaluations for the GAVI-HSS program	
	4.14. Organize a meeting for presenting the mid-project and end-project GAVI-HSS program evaluation outcomes	
	4.15. Provide UNICEF procurement costs (5%) Country procurement process commission (3%)	

13. Results Chain

Objective 1: Strengthen governance and coordination of immunization activities at the central, regional and peripheral levels.

Key activities:

1. Support strategic and operational coordination between the MPH and partners at the central and peripheral levels for the implementation of joint approaches, with the framework of HSTP and the cMYP (TF, HSCC, ICC).
2. Strengthen regional and district management team capacity in regions 1, 2 and 3 for all of their training and supervisory functions.
3. Reinvigorate Primary Health Care entities and community participation.
4. Develop the capacity of ministry representatives at all levels on how to monitor documentation so that decision making is evidence based.

Intermediate outcomes:

1. The immunization Work Group brings the needed technical support to influence ICC decisions (at the immunization services level) and HSCC decisions (which impact the HSS on a larger scale). These groups meet regularly and submit useful strategic recommendations to the MPH so that policy decisions can be made.
2. The regional and district management teams can support and supervise all priority health-related and immunization activities with trained personnel and appropriate material means.
3. The Primary Health Care entities are operational, with members who have been trained, and they have access to appropriate tools. The COGES are involved in the management of the health facilities.
4. The district, regional and central levels have (at least the minimum required) routine information about quality to make decisions. Appropriate studies are produced to complete the analysis (SARA, EVM and other)

Immunization outcomes:

- The immunization activities are conducted in accordance with recommendations.
- Innovative approaches involving the MPH, partners and the population are proposed to improve immunization coverage.
- The steering and coordination of immunization activities are improved at all levels.
- All works responsible for immunization have the proper support and supervision.
- Community workers understand their function as it relates to immunization and epidemiological surveillance.
- The outcomes are documented and monitored regularly and show consistent improvement.

Related key activity indicators:

- Number of meetings held by the immunization TF (technical preparation), by the HSCC (strategic recommendations), the ICC (steering immunization

→

Related intermediate outcome indicators:

1. (Number of) technical recommendation documents produced by the Immunization Task Force for the HSCC, the ICC and the CTAPEV.

→

Related immunization outcome indicators:

1. DTP-HEPB-HIB3 coverage.
2. MCV 1 coverage.
3. Geographic equity of DTP-HEPB-

activities) and the CTAPEV (Committee for Expanded Program on Immunization). ▪ A permanent Project Management Division at the central level. ▪ Material investment made in the regions and districts (infrastructure, office furnishings, vehicles, computers, other) ▪ Number of regions and districts having personnel trained in compliance with MPH standards. ▪ Number of trainings / activities to strengthen capacity for regions and districts. ▪ Supervision frequency at the central level for the regions and districts. ▪ Number of districts with revitalized Primary Health Care (PHC) entities and renewed COGES ▪ Number of studies conducted ▪ Number of district oversight missions and internal and external audits organized.	2. Percentage of strategic recommendations from the HSCC that have been implemented at the policy level and for operational partners. 3. ICC operational rate (number of meetings held with minutes created / reviewed). 4. Execution rate for operational participants with regard to ICC decisions. 5. Execution rate for regions and districts activity plans. 6. Proportion of districts with PHC entities and functional COGES.	HIB3 coverage. 4. Socio-economic equity of immunization coverage. 5. Gender equity of DTP-HEPB-HIB coverage. 6. . DTP-HEPB-HIB 1 – DTP-HEPB-HIB3 dropout rate. 7. Proportion of children who are fully immunized:
Objective 2: Ensure conditions and quality of curative, preventive, promotional services offered in accordance with the minimum package of activities in regions 1, 2 and 3		
Key activities: 1. Renovate and re-equip health facilities in health regions 1, 2 and 3 to provide them with the means to apply the full MPA. 2. Support implementation of outreach and mobile strategies in the 10 targeted health districts 3. Strengthen the search for drop outs using community health workers 4. Re-establish and maintain the cold chain at the central level and the three targeted regions. 5. Provide the central, district and health facility levels with vehicles.	**Intermediate results:** 1. The first-line health facilities selected in the three health regions have appropriate infrastructure equipment. 2. Outreach and mobile strategies have been efficiently implemented. 3. Trained community health workers are available to search for dropouts. 4. The cold chain has been re-established and is operational. 5. The supply chain and the cold chain allow for the regular supply of vaccines and	**Immunization outcomes:** ▪ A selection of first-line health facilities in health regions 1, 2 and 3 are able to implement the complete MPA, integrating immunization. ▪ Improved in immunization coverage ▪ Reduced dropout rate ▪ Reduced wastage rate ▪ No vaccine or input shortages

	inputs.	
Related key activities indicators: ▪ Number of health facilities that have been renovated or re-equipped ▪ Number of personnel assigned to health regions 1, 2 and 3 and personnel turn over. ▪ Number of trainings ▪ Existence of documents supporting outreach strategies ▪ Vehicles and equipment provided for cold chain supply chain.	**Related intermediate outcome indicators:** ▪ Percentage of health facilities with the infrastructure, equipment and personnel in compliance with appropriate operations and security health standards (see HSTP). Evolution of coverage rates before and after outreach strategies implemented. ▪ Rate of vaccine and essential input stock shortage ▪ Vaccine wastage rates due to cold chain deficiencies.	**Related immunization outcome indicators:** 1. DTP-HEPB-HIB3 coverage. 2. MCV 1 coverage. 3. Geographic equity of DTP-HEPB-HIB3 coverage. 4. Socio-economic equity of immunization coverage. 5. DTP-HEPB-HIB 1 – DTP-HEPB-HIB3 dropout rate. 6. Proportion of children who are fully immunized:
Objective 3: Strengthen the quality and use of health-related information for epidemiological surveillance and EPI		
Key Activities: 1. Develop appropriate health information tools for local capacity and essential needs, integrating, at a minimum, epidemiological surveillance and EPI monitoring. 2. Provide training for those participating in health care (MPH, partners, communities) at all levels of data management 3. Strengthen and maintain the network of computers at the central, regional and district levels 4. Organize data harmonization and intervention monitoring meetings at all levels.	**Intermediate outcomes:** 1. Existence of different information formats adapted to essential needs, local capacity and operational service conditions. 2. Availability of trained health personnel 3. Full network of computers operational at the central, regional and district levels. 4. Regular data harmonization meetings and information used in decision making process at different levels.	**Immunization outcomes:** ▪ *Regular production of quality essential health information to be used in decision making.* ▪ *Efficient use of information in decision making at the different stages.*

Related Key Activities Indicators:

- Number of health facilities that have appropriate data management tools and guidelines for the information packets.
- Number of training sessions organized
- Number of information reports sent to the central level that conform to the expected format
- Number of regions and districts who have computer equipment
- Number of harmonization meetings held

→

Related intermediate outcome indicators:

1. Report completeness rates
2. Report timeliness rates
3. Percentage of health facilities that have personnel trained on the health information system
4. Percentage of regions and districts that have operational computer equipment.

→

Related immunization outcome indicators:

1. DTP-HEPB-HIB HepB-Hib3 coverage
2. MCV 1 coverage
3. Geographic equity of DTP-HEPB-HIB HepB-Hib3 coverage.
4. Socio-economic equity of immunization coverage.
5. . DTP-HEPB-HIB-HepB-Hib 1 – DTP-HEPB-HIB HepB-Hib3 dropout rate.
6. Proportion of children who are fully immunized:

IMPACT:

Impact: Contribute to the reduction of the under-five and maternal mortality rate nationally via intervention in regions 1, 2 and 3.

- Burden and mortality related to vaccine-preventable disease are reduced by 50%
- Infant mortality rate is reduced from 116 to 70 per 1000 live births
- The under-five mortality rate has decreased, from 179 to 120 per 1000 live births
- Maternal mortality rate is reduced from 890 to 500 per 100,000 live births

ASSUMPTIONS:

- The three regions and the central level do not experience renewed conflict during the program's duration. Ideally, peace is re-established on a national scale. The country benefits from relative political stability, including during and after the 2015 presidential elections.
- Health personnel accept reassignment to the relevant regions and districts. The social climate is stable (no health worker strike)
- Road security is maintained, allowing for free circulation of people and goods. Other structural elements are progressively strengthened (example: a solution is found for transferring funds / banking system in the regions and districts).
- Entities assisting with national cooperation are active and facilitate the implementation and funding of the Transition Plan. The HIV Sector Committee is reactivated to provide a decision making entity, in light of the strategic recommendations submitted by the other entities (including the HSCC).
- TFP and NGO technical and financial support is maintained or increased overall over the course of the program

- The Government and Ministry of Health respect the conditions of good governance and transparency for the management of the resources affected

14. M&E Monitoring and Evaluation

I. Framework for monitoring and evaluation

The main entities for monitoring and evaluation are the following:

At the central level

1. The HIV Sector Committee chaired by Madame the Minister of Health has been the official entity in charge of monitoring and evaluation of the implementation of national policies and strategies since 2008 (including HSTP and cMYP) and the only entity authorized to make policy decisions. Its reactivation is on the minister's agenda.
2. The HSCC was created to be a strategic recommendation entity with the HSTP, with no decision-making power (which, in theory, belongs to the CSS-HIV). It is made up of a limited number of representatives from the MPH, the TFPs and the NGOs.
3. The EPI Interagency Coordination Committee chaired by the Minister of Health has a mission of M&E and also to coordinate all EPI activities. This is the entity that holds decision making power about immunization activities. It integrates all of the EPI's TFPs.
4. The following are part of the Directorate for Planning and Research:

- The Statistics Department and Health Information, responsible for collecting, validating, analyzing and disseminating health information;
- The Planning, Research and Assistance Department in charge of monitoring and evaluation and implementation of the State budget;
- The Documentation and Archives Department

5. The EPI Directorate includes

- The EPI Data Monitoring and Evaluation Department;
- The Administrative Service and Logistics Department.

At the decentralized level

1. The Regional Management Teams which are the decentralized entities in charge of the health system governance at the regional level (training, supervision, planning, etc.).
2. The District Management Teams which are the operational entities in charge of training on health activity implementation.
3. The prefectural and regional committees on Primary Health Care integrate the civil society organizations.
4. The Under Office for UN System Agencies Health Cluster

II. Mechanism for monitoring and evaluation

The mechanism for monitoring and evaluation will be on a regular basis (monthly, quarterly, twice-yearly and annually). Implementation of the GAVI-HSS monitoring and evaluation activities will align with the existing national provisions as well as the use of existing national indicators, data collection tools and systems for establishing reports.

Data from the survey on the availability of the *health service offerings* will also be updated. The *MICS* V survey data will enable decisions to be taken such as how to update strategies, programs and plans.

Routine data collected within the context of the NHIS will not currently allow monitoring and evaluation at each level of the system. This is why one of the objectives of this application is the strengthening of the essential information system, to eventually provide the conditions needed to relaunch the full routine NHIS.

Supportive supervision is a means through which to strengthen the capacities of health facility personnel. The supervisory and monitoring system was damaged by the destruction of the regional and district management teams and the risks inherent to travel in the country's interior. The focus will first be on developing integrated formative supervision formats that will be adapted to the capacity of the current regional and district participants. They will be differentiated as needed in Health Region no. 3 depending on the levels of operations and security and the presence of partner organizations (NGOs, TFPs) that are capable of supporting supervision activities.

Monitoring using a mechanism created to evaluate health facility performance.

This includes locally evaluating activity coverage using various coverage determinants. To do this, the indicators were selected for each of the determinants. It is important to remember that the technique of monitoring was introduced into the CAR health system in 1984.

Quarterly meetings on *coordination epidemiological surveillance and routine EPI* allow for identifying the operational problems that prevent immunization activities from being properly executed, analyzing their causes and determining corrective strategies to be implemented at the operational level while considering the resources available

An annual review will be integrated into the Joint Annual Review of all Health activities (financed outside of this program), to evaluate what outcomes have been attained and to formulate the appropriate recommendations. The first Joint Annual Review is scheduled for 2016.

An evaluation of the Gavi-HSS program will take place mid-project (2017) and end-project (2018).

The M&E plan in appendix details the indicators used, reference values and target values

as well as collection sources.

III. Data sources

1. Routine data collected via the NHIS under the responsibility of the Directorate for Planning and Research;
2. The epidemiological surveillance data from the Directorate of Preventive Medicine and Disease Prevention (DMPM):
3. Data from the EPI Directorate;
4. The joint MPT/WHO/UNICEF reporting form;
5. The data from the surveys (ICS, MICS, HeRAMS, etc.).

Most of the data will be disaggregated by region. The monitoring and evaluation context provides national coverage targets. The performance for the three regions will, then, be measured separately so that GAVI-HSS performance can be measured independently of the immunization activities in the rest of the country.

IV. Key monitoring and evaluation activities to be financed by the application

Within the context of this application, these activities are:

1. Develop appropriate health information tools for local capacity and essential needs, integrating, at a minimum, epidemiological surveillance and EPI monitoring.
2. Train national participants on data management at all levels
3. Develop and maintain the central level's network of computers as well as that for the regional and district management teams.
4. Organize data harmonization and intervention monitoring meetings at all levels.
5. Organize the supervisory missions in the three targeted regions

V. The budget allocated for the monitoring and evaluation plan

The application devotes USD 88,056, or 1% of the total proposal budget, to financing the monitoring and evaluation activities. It also necessary to note that the Health Information System is currently being strengthened with funding from the Global Fund to improve the monitoring and evaluation of the implementation of the health interventions.

PART E – BUDGET, GAP ANALYSIS AND WORKPLAN

15. 15. Detailed Budget and Workplan Narrative

The total Amount available for this GAVI-HSS application for CAR is USD 7,560 million. The period covered by this support is 2016-2018 and the distribution of this amount per year is shown in the table below.

Table6: Distribution of application amount per year

Year	*Total amount available*
2016	*3,024,000*
2017	*2,268,000*
2018	*2,268,000*
Total	**7,560,0000**

1. **Explanation of unit costs within this application budget.**

To evaluate the cost of the selected activities in the context of this application, we have combined the method of historic costs and that of fair market value.

The historic costs were inspired by the unit costs used in the country's programmatic documents (NHDP II, HSTP, PPCA, etc.) and also by costs recently used in the context of cooperative programs that are currently in process. These are the costs used in the following contexts:

- applications to the Global Fund and the World Bank;
- request for funding from UNICEF, UNFPA and WHO;
- Beku fund contracts;
- humanitarian initiatives in the health sector.

Unit costs based on the principle of fair market value were either created based on historic costs (to which the country's inflation rate has been applied: 13%) or market prices adjusted to what is offered by the supply chain.

In the first instance, we can cite the example of construction, renovation and equipment work in health facilities.

The second instance was applied to the vehicle fleet (vehicles, motor bikes, bicycles), computers and other office supplies acquired through the UN procurement system. In this instance, evaluation of unit costs does not take taxes and fees or logistic costs into account.

The principle of fair market value was also used in determining training unit costs. The actual charges required to organize a training session was evaluated in relation to training items or training goals. Each time, significant adjustments were made to take possible unforeseen implementation issues into account.

In summary, unit costs used for the costing of the activities selected in this application followed the costing logic used in the context of the Health Sector Transition Plan (HSTP).

Some activities were evaluated as a lump sums in the "Budget Gap Analysis and Work Plan" tool, due to the fact that their implementation requires numerous details that have been outlined in our "Basis for GAVI-HSS Application Calculations" file, attached as appendix to this application. From this document, we can cite: coordination meetings, insurance and maintenance costs, large construction or large purchases.

The quantities of input units are determined in relation to the Health Sector Transition Plan's objects as well as those of the cMYP. The "Basis for GAVI-HSS Application Calculations" file describes how most quantities were selected in the context of this application.

To better understand this application's budget and the budget in general, we are providing details below on the costing used for the main budget line items.

Objective 1

1. Means of transport

The most important line items for this objective have to do with procuring means of transport as well related items: insurance, fuel and maintenance.

To determine the overall cost of fuel, the assumptions below were used:

- Average cost per liter of fuel: USD 2;
- Average distance driven per year: 12,000 km;
- Number of vehicles included: 17, of which 5 are procured through this application and 12 others are in the process of being procured or have already been procured with other funds;
- A vehicle's consumption: 15L/100 km.

Regarding maintenance, this application only takes into account ongoing maintenance costs: tires, oil changes and small repairs. A line item will be included in the state budget for "vehicle maintenance" for repairs needed.

The basis for the calculation included in the appendix provides more detail.

Objective 2

1. Solar refrigerators

The unit cost to procure solar refrigerators is USD 6,530 (UNICEF). The total number of refrigerators required in the targeted zones is 495 units, 190 are currently in use or being procured with UNICEF funds (120), WHO funds (50) and with GAVI reprogramming funds (20). This results in a gap of 305. This application proposes the procurement of 78 refrigerators. The remaining gap can be addressed by other sources of funding for which the country does not have a clear source at this time.

2. Cold chain maintenance

The process of contracting with a maintenance service provider for the cold room at the central level is in progress. The amount for this operation is USD 15,000 per year.

The cost of maintenance for the refrigerator installed at the peripheral level was estimated by apply a rate of 5% of the cost of the acquisition. For this line item, the total number of refrigerators that will be available in the field from all funding sources was considered.

3. Incentive measures at the operational level

The cost of this line item follows what is currently actually being done within the context of reprogramming.

4. Human resources

The average cost of compensation for a health worker is USD 3,000, based on the levels of compensation noted in the directives on free care (a State Registered Nurse with Degree - IDE).

The total need for health workers is not yet available. The country is currently conducting a wider study in this area. The study will include a complete analysis of the situation, a redeployment plan after demobilization, a gap analysis that takes into account NGO actions.

5. Community action

Two approaches were adopted to strengthen community action: indirect contracting via the CSOs and direct contracting with multidisciplinary community health workers. How to implement these two approaches is still being decided upon. Among others, it will be a question of capitalizing on the various opportunities for funding, now and in the future. Specially, the Beku Funds, Global Fund, the World Ban and the European Union.

In the meanwhile, this application includes the contracting of 300 community health workers as well as a grant for 5 CSOs. The CSO grant will mainly be used to strengthen CSO managerial capacity. The resources necessary for their deployment will provide other funding opportunities.

6. Medicine supply chain

To face the difficulties of resupplying health facilities with medicines and vaccines, the country has opted to strengthen the means of logistics, specifically transport as well as renovations to regional supply centers.

For transport, the procurement of 2 10-ton trucks has been planned at a unit cost of USD 216,000.

As for renovations to regional medicine stores, areas that need significant renovations have been identified within the zones that are the target of the current funding. However, a detailed study is needed the first year.

7. Outreach and mobile strategies

Operational costs for outreach and mobile strategies are xxxxxx.

8. Renovations

Here, the renovations are for all the work and equipment needed to make operational the health facilities that suffered damage due to the events the country experienced in 2013.

In the zone targeted by this application, 13 health centers experienced partial damage (see 2014 HERAMS survey). According to the same source, all these health facilities were operational when the survey was carried out. The cost of renovating the buildings for one of these health facilities within this context was capped USD 67,940, which is a fourth of the cost of the constructing a new health facility4.

In addition, all of the 13 health facilities need to be totally re-equipped and three of them will be provided with a source of drinking water. The unit costs for a health center equipment kit, the creation of a source of drinking water and a source of energy are, respectively, USD 30,000 and USD 20,000.

Objective 3

Specific goals for this objective are: strengthening the computer system, the statistical yearbook and the development of collection and data analysis tools. However, it should be noted that the Global Fund is planning to invest significant resources in this area in the short term.

2. Budget framework

The distribution of the application budget per objective is shown in the table below.

Table7: Budget framework per objective

Objective	2016	2017	2018	Total	%
1. Objective "1": Strengthen governance and coordination of immunization activities at the central, regional and peripheral levels.	790,985	239,402	394,778	1,425,164	**19**
2. Objective "2": Ensure the quality of curative, preventive, promotional services offered in accordance with the minimum package of activities in regions 1, 2 and 3	1,678,998	1,415,359	1,229,154	4,323,511	**57**
3. Objective "3": Strengthen the quality and use of health-related information for epidemiological surveillance and EPI	139,972	123,472	149,972	413,416	**6**
4. Program management	414,046	489,767	494,096	1,397,909	**18**
Total	**3,024,000**	**2,268,000**	**2,268,000**	**7,560,000**	

This distribution follows the country's current context. As noted above, after the socio-political crisis of recent years, the country needs to rebuild not only buildings, but also the administration that was destroyed during the troubled events. This justifies the fact that 19% of resources are assigned to objective 1.

Objective 2, which is directly linked to immunization, obviously uses over half of the resources (57%).

6% of the application will be assigned to developing the health information system.

18% have been set aside for objective 4 (program management), including 8% for procurement costs and 10 % for project management supplies.

Budget distribution per implementer

The distribution of resources per activity implementer is shown in the table below:

Table8: Budget distribution per implementer

Implementers	2015	2016	2017	Total	
EPI Directorate	23,387	22,568	47,195	93,149	**1%**
Directorate for Planning and Research	611,170	619,277	578,277	1,808,724	**24%**

[4] See Unit Cost of constructing a new health facility in the HSTP

Directorate for Health Infrastructure	407,641	655,581	188,896	1,252,117	**17%**
Directorate for Community Health	39,500	76,500	16,500	132,500	**2%**
Health Regions and Prefectures/HDs	492,338	492,311	545,948	1,530,597	**20%**
Civil Society Organizations	104,000	104,000	104,000	312,000	**4%**
WHO	80,500	35,500	39,500	155,500	**2%**
UNICEF	1,265,464	262,264	747,684	2,275,412	**30%**
Total	**3,024,000**	**2,268,000**	**2,268,000**	**7,560,000**	

30% of the resources (30%) will be under UNICEF control, and 8% of these are reserved for procurement, and specifically for UNICEF's role as the main procurement entity.

Directorate for Planning and Research will monitor the execution of 24% of the support provided by this application.

In this budget, WHO will lead the development and publishing of the health statistics yearbook, technical assistance and the procurement of computer and office equipment that makes up 2% of the support.

The low amount of resources directly assigned to CSO management is justified by the fact that the organization of community action is currently under construction in the country.

The process of contracting with the CSOs to have a more solid partnership with the health system is ongoing. The country envisages that, at the end of this process, community system will be profoundly reformed, specifically with regard to the training and recruitment of multidisciplinary community health workers. Other funding will be mobilized within the context of the implementation of the Health Sector Transition Plan. In the meanwhile, the country has budgeted here the resources needed to train and compensate the community health workers in the targeted regions (HR1, HR2 and HR3).

It is also important to note that 20% of the resources will be directly assigned to the operational level.

The infrastructures, (i) renovation and equipment for the health facilities, (ii) and renovation of administrative structures at the decentralized level.

16. Gap Analysis and Complementarity

Alignment of the application's objectives with those of the HSTP.

Objective "1": Strengthen governance and coordination of immunization activities at the central, regional and peripheral levels.

This objective results from the main objective of the HSTP's first objective: Revitalize the health sector's system of coordination at all levels of the health pyramid between now and 31 December 2016.

This takes into account the need to more visibly break down the efforts to develop the information system. The related costs have been removed from this objective and assigned to objective 3.

Objective "2": Ensure the quality of curative, preventive, promotional services offered in accordance with the minimum package of activities in regions 1, 2 and 3

This objective is the operational breakdown of immunization costs for the HSTP's objective no. 2: Offering the minimum package and the complementary package of activities to the entire target population between now and 31 December 2016

Objective "3": Strengthen the quality and use of health-related information for epidemiological surveillance and EPI

This objective targets the strengthening of the health information system, with a specific focus on the collecting, processing and disseminating immunization information.

Table9: Table of financing gaps

Objectives of the HSS proposal	Resource needs	Total Financing	Financing gap	GAVI HSS
1. Objective "1": Strengthen governance and coordination of immunization activities at the central, regional and peripheral levels.	121,014,468	98,719,231	22,295,237	***1,439,444***

2. Objective "2": Ensure the quality of curative, preventive, promotional services offered in accordance with the minimum package of activities in regions 1, 2 and 3	57,966,426	24,184,288	33,782,139	***4,311,231***
3. Objective "3": Strengthen the quality and use of health-related information for epidemiological surveillance and EPI	2,576,926	0	2,576,926	***413,416***
4. Program management	0	0	0	***1,395,909***
Total	**181,557,820**	**122,903,518**	**58,654,302**	**7,560,000**

According to this table, 68% of funding needs are covered.

With a contribution of 4%, GAVI-HSS joins the partners who have already announced their funding for the policy of health transition in CAR. As shown in the costing tool table ("Gap Analysis" worksheet), WHO, Bêku Funds, UNICEF, World Bank as well as the Government are the main donors for CAR health system.

17. Sustainability

Currently, the Central African Republic is again a country in crisis, and it is strongly dependent on the financial and operational plans for external aid and NGO intervention.

It is obviously not possible at the current time to make solid three-year projections about stabilization of the security situation, the degree of operability of health services or the state of Public Finances.

As a result, the question of sustainability cannot be understood as a commitment by the Ministry of Health to assume an increasing part of the system's operations or their funding. However, the minister and the minister's partners can implement strategies to optimize the use of resources and create conditions favorable to securing future budgets. The overriding principles of the program go in this direction.

- Therefore, the GAVI-HSS program is in line with the HSTP and the coordination work between participants carried out within the HSCC, to which the ICC refers. According to these terms of reference, the HSCC objectives are specifically: to assist the government with maintaining a realistic analysis of the situation in the health sector: to provide the minister with technical expertise from TFP and NGO partners and operational experience within the country to facilitate the formulation of strategic recommendations (…); document results and offer conditions that are favorable to attracting additional funding from current and future financial partners, by demonstrating efficient joint approaches.
- In comparison with previous programs, the new GAVI-HSS proposal has a strong focus on the integration of immunization activities within the Minimum Package of Activities, to be generalized for all health facilities. This same desire is found to extend this approach to health centers and outposts, and not only to EPI centers.
- The program seeks to reestablish the peripheral level's capacities for the long-term. This is accomplished via support for the redeployment of personnel and the strengthening of competencies within the health facilities; by focusing on the relaunch of training and supervisory activities for regions and districts; and through the reactivation of community health entities for health facilities and the population.
- The infrastructure and equipment efforts focus on recreating capacity that allows for preventive and curative care that are sustainable after the program is complete. There will also be renovation and re-equipment, transportation fleet provided for the cold chain and the supply chain.

In addition to that, there are, obviously, some line items for which funding is not guaranteed. This customized approach approved by GAVI has authorized the funding of contract personnel for the health facilities, for which an alternative solution must be found in the future. Provisions for the cold chain, vehicle fleet and other fuel needs, maintenance and operations costs. The overall goal of the proposal is that it contribute to showing a significant potential for increasing immunization coverage and stimulating active cooperation between the MPH, TFPs, NGOs and CSOs, based on proactively seeking out solutions using domestic and external resources.

To what has been mentioned above, it is important to add the public finance reforms currently in progress within the country, and specifically, the introduction the program budget. The Ministry of Health was selected as the responsible ministry. The introduction of this tool will make the health programs more attractive to new sources of funding and national sources.

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

18. Implementation Arrangements

Entities responsible for steering the program

Directorate for Planning and Research is responsible for implementing and managing the GAVI-HSS support. Steering of the GAVI-HSS program will be overseen by the ICC, in dialog with the HSCC.

Entities responsible for daily program management

The technical implementation documents will be prepared by the Project Management Division. The Division will be responsible for the daily management of coordination and M&E activities for the proposal and will report directly to the ICC.
A multi-participant task force (TF) for Immunization will be created to carry out the technical preparatory work required for the ICC meetings and decisions, and possibly for the HSCC. The Immunization TF will work in collaboration with the EPI Technical Support Committee (CTAPEV) to ensure the integration of the GAVI-HSS program into national immunization guidelines.

Main steering functions

The ICC will play the following roles:

- approval of annual GAVI-HSS proposal implementation plans for CAR;
- alignment of the Health Sector Transition Plan's implementation interventions
- approval of application's disbursement plans;
- provide monitoring of proposal implementation during bi-monthly or quarterly meetings;
- annually evaluate the implementation of the proposal within the context of the health sector's Joint Annual Reviews;
- initiate audits on financial management and the HSS-GAVI fund accounts;
- initiate mid-project and end-project evaluation for the GAVI-HSS CAR proposal

The ICC will work in close collaboration with the HSCC for strategic recommendations about the implementation of the overall Transition Plan

Application implementation partners

The application implementation partners are UNICEF and WHO. They will work with the Ministry of Health's entities and departments, and with NGOs at all levels to guarantee the required synergies as well as results. UNICEF will be in charge of all supply and renovation activities (with the exception of call for tender mechanisms by MPH's procurement department). WHO will be in charge of all institutional support activities.
The choice of these two partners for the implementation of this application results from an in-depth analysis that was conducted by the Ministry of Health and various partners. Their goal was to gain maximum benefit from the opportunity being offered by GAVI's support for an efficient health system strengthening. This decision was based on the following:

- The desire to restore the Ministry of Health to funds management via the Project Management Division, strengthened by an accountant, in comparison to the 2014-15 reprogramming when all funds management was the responsibility of UNICEF.
- The re-establishment of the requirement for two signatures, from the Minister of Health and the WHO representative, to ensure transparency and good governance with regard to the use of resources.
- The government recognizes WHO and UNICEF's technical expertise with regard to health system strengthening and immunization.

Mechanisms for receiving and managing GAVI-HSS resources

The recommended management mechanisms can be summarized as follows:

1. GAVI sends the funds to the government who receives them into the DEP GAVI account;
2. A Workplan is established for the program action plan and submitted for approval by the ICC and all partners.
3. The requests are made by the technical departments for funding activities, transmitted to the DEP.
4. A request for disbursement of GAVI-HSS funds is cosigned by the DEP and the Minister of Public Health

based on these disbursement requests.

5. After being approved by the Minister (the President of the ICC) upon request for disbursement, a check will be made out to be signed by the authorized co-signatories who are the Minister and the WHO representative. A list of alternates will be available in the absence of the two signers.
6. The MPH, WHO and UNICEF execute the project in accordance with their administrative and financial management rules and report the outcomes obtained and on their financial management.
7. The technical and financial reports prepared by the MPH, WHO and UNICEF are submitted to the ICC.

A joint memorandum of understanding was signed by the Ministry of Health and Population and the WHO and UNICEF representatives in Congo to develop and agree upon the modalities for implementing the project as well as each party's obligations.

Application implementation mechanisms

Annual planning.
Each health district or region and all other facilities involved in the this funding will develop an integrated action plan (IAP) for HSS. This plan will specify the activities before they are funded by GAVI-HSS and those to be funded by other partners, including the government. These IAPs will be consolidated at the intermediary level and then at the central level. The IAP activities consolidated at these two levels which will receive GAVI funding will then be merged into a budgeted annual work plan (referred to as PTBA in French). In collaboration with the Ministry of Health's technical services group, WHO and UNICEF will develop disbursement plans, based on the PTBAs. The budgeted annual work plan and disbursement plans will be presented to the ICC for approval before they are submitted to GAVI.

Funding accounts
The annual disbursement plans submitted to GAVI will be reviewed and approved regarding the disbursement of funds to the DEP, annually, so that the activities included in the PTBAs can be implemented. The funds transferred to the DEP will be deposited directly in the HSS-GAVI account opened by the Ministry of Health.

Funds management.
Funds management will mainly be conducted by the Ministry of Health, in compliance with current accounting standards, and requiring a co-signature by WHO for all disbursements.

Implementation of activities.
For the implementation of activities, each health district and region will draft a quarterly work plan that refers back to the PTBA. Each implementation facility will draft a funding request that will be addressed up the hierarchy to the Directorate for Planning and Research that will begin the disbursement process in compliance with the GAVI-HSS resource management mechanisms described above. The central level will make resources available to the regions and the districts while waiting for local bank branches to resume activity within the country's interior. Currently, funds transfers to the decentralized levels are carried out by MPH workers when they are in the field, with release signatures at the various levels.

Operational monitoring of activities.
This monitoring is the responsibility of the entities in charge of execution; they receive support and assistance from WHO and UNICEF. At the health regional and district levels, senior staff will conduct the monitoring during supportive supervision of health facility workers, when the monthly activities review meetings take place, during exercises to monitor coverage and DQS. The same process will be used for the health regions. The health departments monitor the health district activities. At the central level, the DEP and the relevant technical directorates will monitor the implementation of their own activities as well as monthly monitoring of the regions. The civil society organizations will monitor community-level activities. A quarterly, twice-yearly and annual technical project activity implementation report will be drafted by the implementing facilities; these reports will be submitted to DEP.

Strategic monitoring and evaluation
The DEP is responsible for this type of monitoring. This monitoring will combine operational monitoring with research into the health system, studies and other analysis. The monitoring will occur in relation to other studies and analyses about the health system being funded otherwise.

Resources allocated to program management.
The program will be managed by the Central Support Team that is under the authority of the DEP and in compliance with the rules discussed above.
An annual internal and external audit is scheduled to ensure transparency in resource management.

Technical assistance.
Two technical assistants are planned for, within the context of the HSTP implementation to provide institutional support to the Ministry of Health. One of them (the one who is programmed in this application) will integrate support for DEP into his activities as well as support for resource management by the Project Management Division.
Other international and national technical assistance questions are discussed in detail in section 20 of this proposal.

19. Involvement of CSOs

In CAR, the CSOs were organized into networks or associations similar to the *Association des Œuvres Médicales des Églises pour la Santé en Centrafrique* (ASSOMESCA) [Association for Church Medical Works for Health in CAR].

The CSOs have national headquarters. Some CSOs, specifically ASSOMESCA, have contributed to the developing the health map by creating health facilities and peripheral pharmaceutical stores, to the training of health workers at all levels within the health care system and results based funding.

However, general CSO involvement in health activities, including immunization activities, needs to be strengthened.

Toward this end, the Ministry of Public Health launched a call for a show of interest in 2015 about contracting with the Civil Society Organizations within the context of Health Sector Transition Plan and GAVI-HSS implementation.

The CSOs will be involved in the implementation of monitoring and evaluation at several levels and within several areas.

1. **At the national level:** CSOs are ICC members and participate in strategic decision-making meetings for immunization issues. Some CSOs are involved in preparing this application.
2. **At the regional and district level:** The existence of provisions within the regulatory texts about the creation and operation of Primary Health Care entities address the participation of NGOs/CBOs and CSOs in Regional and Provincial Primary Health Care Committees. Within the context of the GAVI-HSS project M&E entities, the CSOs will participate in Committee decisions (regional or provincial, depending on the level). The regular participation of the CSOs in PHC meetings include their involvement in approving the annual GAVI-HSS Workplans; the monitoring of program and financial implementation; monitoring of attainment of targets and the approval of progress reports at the regional level
3. **At the health clinic level:** The national HeRAMS survey revealed that around 5% of health facilities are religious. The CSOs participate in health facility management meetings within the Health Center Management Committee and the Hospital Management Board.
4. **Within the community**: The CSOs will also have an important role in implementing health actions at the community level (community activity packages, including promoting immunization, active research on dropouts) by involving youth clubs and associations; religious CBOs (religious movements and associations: scouts, vigils)

4% of the GAVI-HSS support has been allocated to the CSOs for the training of civil society participants and organization grants to support their actions supporting immunization.

20. Technical Assistance

The GAVI-HSS proposal is closely integrated with the HSTP and will benefit from the support provided to the Transition Plan. Two programs currently plan for long-term technical assistance (TA) at the central level: WHO's "Reestablishing the Health System in Central African Republic" project being financed by the EU, and the Bêku multi-donor Health Fund action sheet.

It was agreed that the WHO TA would be focused on issues related to the central level (organizational reforms, the health policy planning cycle, policy and strategy development, cooperation and coordination with partners, etc. as well as Bêku support focusing on the decentralized levels (tools and procedures, upstream planning, supervisory formats, determination of standards and strategies adapted according to the principle of differentiated approaches, selection of key indicators, etc.). As we see, these activities are directly related to the GAVI-HSS proposal's specific objectives and activities.
The GAVI-HSS proposal also provides for a series of specifically focused consulting to support the development of certain technical aspects of the program. This specifically addresses:

- Developing software specific to the national context to process health information at all levels (see 1.1.) ;

- Developing a detailed manual about all aspects of administrative, financial and accounting management relevant to the GAVI-HSS project (see 1.2.) ;
- Mapping the MPA/CPA per intervention zone (health areas covered by the health facilities in the 10 existing HDs and in the 09 new HDs) (see 1.13.) ;
- 2018 Evaluation of Effective Vaccine Management (see 1.15);
- Implement visible support (see 1.20.) ;
- Developing the new GAVI application at the end of 2018;
- Developing MPA standards adapted to operational and security conditions, developing tools and guidelines for increasing awareness, and monitoring of the implementation (see 2.14);
- Developing formats, procedures and tools for the different packages within the information system, using minimum requirements for epidemiological surveillance and EPI for a complete NHIS (see 3.3);
- Training personnel to use NHIS tools (see 3.4.) ;
- Retraining or training the district management teams on DQS methodology (see 3.5);
- Provide international expertise for the yearly development of the health statistics yearbook (see 3.7) ;
- External audit of program accounts (4.11) ;
- Joint evaluation at program at mid-project and end-project (see 4.13.).

21. Risks and Mitigation Measures			
Description of risk	**PROBABILITY (high, medium, low)**	**IMPACT (high, medium, low)**	**Mitigation Measures**
Objective 1: Strengthen governance and coordination of immunization activities at the central, regional and peripheral levels.			
Institutional Risks: *- Delayed HSCC implementation* *- Difficulties reassigning personnel to the regions and districts*	*Low* *Medium*	*Medium* *High, due to security issues and local conditions.*	*- ICC advocacy + partners to support MPH and HSCC* *- Search for joint solutions within HSCC: bonus mechanisms; support installation.*
Fiduciary Risk: *- Project Management Division's management capacity* *- Lack of a banking system at the decentralized level*	*Low* *High*	*Medium* *Weak*	*- Support PMD with central technical assistance* *- Current solutions. Seek an inter-sector solution led by HSCC*
Operational Risk: *- Poor worker capacity in the regions and districts to train and supervise* *- recurring deficiencies in the information system and documentation*	*Medium* *Medium*	*Medium* *Medium*	*- support provided during and after reassignments via training, integrated formative supervision, etc.* *- continuity of related strengthening activities*
Programmatic and Performance Risk: *- Delayed reporting and funds disbursement*	*Medium*	*Medium*	*Ongoing institutional technical assistance + ICC to respect the schedule.*
Other Risk: *- Renewed hostilities, pillaging, insecurity*	*Low to Medium*	*High*	*- Monitoring of security situation. Ongoing communication with GAVI. Possibility of reprogramming.*
Overall Risk Rating for Objective 1			
Objective 2: Ensure conditions and quality of curative and preventive services offered in accordance with the minimum package of activities in regions 1, 2 and 3			
Institutional Risk: *- Poor capacity to provide training at the health*	*Low*	*Medium*	*- monitored by the ICC and the*

facilities (at the regional, central and other levels) *- Difficulties with cooperation / coordination between local authorities and international NGOs.*	*Low*	*Weak*	*HSCC and training improvements* *- Advocacy, negotiation. This does prevent GAVI-HSS operations*
Fiduciary Risk: *- poor resource management capacity in regions and districts and health facilities*	*Medium*	*Low*	*- to monitor using review and audit mechanisms.*
Operational Risk: *- Geographic gaps when implementing the MPA, due to budgetary limits* *- Departure of a large number of NGOs during the conflict*	*Medium* *Medium*	*Weak* *Medium*	*- Consensual equitable health facility intervention planning + HSCC advocacy to support the health map by other means.* *- To be addressed within the HSCC. Quick departures may indicate a fall in support for the MPA*
Programmatic and Performance Risk: *- Delays in programmed actions, specifically renovations and equipment.*	*Medium*	*Medium*	*- Provisional planning of purchases. Monitoring the procurement system*
Other Risk: *- Renewed hostilities, pillaging, insecurity*	*Low to Medium*	*High*	*- Monitoring of security situation. Ongoing communication with GAVI. Possibility of reprogramming.*
Overall Risk Rating for Objective 2			
Objective 3: Strengthen the quality and use of health-related information for epidemiological surveillance and EPI			
Institutional Risks: *- Conflicts about responsibilities between the directorates in charge of the NHIS and epidemiological surveillance* *- Difficulties convincing partners to use the same tools and formats*	*Low* *Low*	*Low* *Low*	*- mediation by ICC* *- HSCC round table and mediation*
Fiduciary Risk: *No particular risk for this objective*			
Operational Risk: *- Difficulties with acceptance and consolidation of various formats for health information (from epidemiological surveillance to NHIS)* *- Coexistence of various formats and reporting by the partners*	*Low* *High*	*Weak* *Low*	*- risk to anticipate the design of informational formats + preparation of training* *- Advocacy. This only harms the quality of consolidation.*

- Capacity of participants to manage the formats (timeliness, completeness, compilation, etc.)	*Medium*	*Medium*	*- continue strengthening efforts (supervision, training, etc.)*
Programmatic and Performance Risk: *- Delayed reporting and data compilation*	*Medium*	*Medium*	*- Continue strengthening capacity and training activities*
Other Risks:			
Overall Risk Rating for Objective 3			
Please add more rows for additional objectives…			

22. Financial Management and Procurement Arrangements

Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.	A GAVI-HSS bank account is opened at a commercial bank, EcoBank in Bangui, the capital. The account signatories are the Minister of Health and the World Health Organization's Representative in the Central African Republic. Each signatory has two alternates: two managers designated by the Ministry of Health (i) the Ministry of Health's Cabinet Director (DIRCAB) (ii) the Director General of Central Services and Hospital Establishments (DGSCEH); two WHO managers (iii) the MPN (iv) the immunization Advisor. The central level will make resources available to the regions and the districts while waiting for local bank branches to resume activity within the country's interior. After the activities in the annual plan drafted by DEP have been approved, they are validated by the ICC. The funding requests are prepared by the central directorates in charge of activities and send to the Directorate for Planning and Research (DEP) to be processed. The checks are filled out by the GAVI/HSS manager at the DEP and transmitted up the hierarchy (after being stamped by the DIRCAB and the DGSCEH) to be signed by the Minister of Health and the WHO Representative. The funds are then placed, according to the expense line item, at the disposition of WHO, UNICEF or the Central Directorates in charge of supporting and executing the activities at the regional or district level, or sent directly to the district management team in charge of activity implementation. The technical and financial reports are then sent to the DEP as documentation.

Question (b): Financial Management Arrangements Data Sheet

1. Name and contact information of Focal Point at the Finance Department of the recipient organization.	Ministry of Health and Population PO Box 883 Bangui Avenue GAMAL NASER
2. Does the recipient organization have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES - GAVI - WHO. - UNICEF - AFD - WORLD BANK
3. **If YES** • Please state the name of the grant, years and grant amount. • For completed or closed grants of Gavi and other development partners: please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going grants of Gavi and other development partners: please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	Yes, GAVI funds for HSS in CAR in the amount of US $3,163,000 have been deposited to cover the implementation years 2008 and 2011 to 2014. The absorption rates are low and HSS funds were reprogrammed to take EPI activities into account, but without express notification to GAVI's Executive. In 2014, transitional management of remaining funds and of the last disbursement of US $679,000 was the responsibility of the country's UNICEF office, in light of the crisis that the country experienced.

Oversight, Planning and Budgeting

4. Which body will be responsible for the in-country oversight of the program? Please briefly describe membership, meeting frequency as well as decision making process.	The entity responsible for reviewing the program in the country will be the Inspection for Administrative and Financial Services, assisted by the Inspection for Pharmaceutical Services. Quarterly reviews will be organized in the regions and districts benefiting from GAVI support. The reports for these missions will be presented to the ICC for decision making.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	The Ministry of Health and Population's Department of Research and Planning will be responsible for planning, budgeting and creating annual progress reports (APR) related to the GAVI-HSS proposal.
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	A proposal implementation plan will be developed each year. It will be approved and adopted by the ICC, in close collaboration with HSCC to ensure integration with the HSTP. This annual plan will be developed with the participating parties, managers of the districts benefiting from the GAVI to ensure complementarity between the activities financed by the government and all partners participating in the health sector.
7. Will the GAVI-HSS program be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to program)? Please provide the list of the authorized signatories for the release of funds and all requests for additional funds.	The account will be funded in foreign currency, i.e. American dollars ($ US) and disbursements for the implementation of HSS activities will be made in local currency, i.e. CFAF. The signatories are the Minister of Health and the WHO Representative in CAR
9. Will GAVI-HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	The HSS funds from GAVI will be transfered to a bank account opened at ECOBANK in Bangui specifically to receive GAVI grants.
10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	To guarantee better tracking of GAVI funds, this bank account will only receive deposits of GAVI funds.
11. Within the HSS program, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled.	NO Lack of bank branches in the interior of the country precludes planning for transfers to the decentralized levels. Once the system has been reactivated and considered reliable, transfers will be made via local bank offices that have been opened in some of the Prefectures. This will specifically depend on secure the zones covered by the GAVI-HSS are.
Procurement	
12. What procurement system will be used for the GAV-HSS Program? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	For significant investments like cold chain equipment, vehicles and other, the bid process will be carried out by the 2 implementation partners (UNICEF and WHO) who will apply the UN rules and system to this process. For renovation/construction work, national procurement procedures will be applied
13. Are all or certain items planned to be procured through the systems of Gavi's	

in-country partners (UNICEF, WHO)?	Yes procurement via UNICEF/WHO
14. What is the staffing arrangement of the organization in procurement?	N/A
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES The Inspection for Administrative and Financial Services is the competent entity
16. Is there a functioning complaint mechanism? Please provide a brief description.	NO
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	NO
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organization in accounting, auditing and reporting?	The Project Management Division will be strengthened by the recruitment of an accountant, in addition to the administrator that is currently in charge.
19. What accounting system is used or will be used for the GAVI-HSS Program? (i.e. Is it a specific accounting software or a manual accounting system?)	The accountant will use the accounting software in all its configurations as applied to the procedures described in the administrative, financial and accounting procedures manual for the program.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	The technical and financial reports are quarterly. The summary is created by the facility responsible for program implementation during the ICC meetings.
Internal control and internal audit	
21. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES The manual of administrative, financial and accounting procedures is developed and made available to the Project Management Division
22. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES Yes, the Inspection for Administrative and Financial Services is the internal reviewing entity at the Department of Health. It will carry out missions via the PMD, and in the regions and districts receiving project support.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES/NO
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[5]	YES
25. Who is responsible for the implementation of audit recommendations?	The Directorate for Planning and Research

[5] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.