\*

**Health Systems Strengthening (HSS) Cash Support**

**Application Package – Proposal Form**

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

|  |
| --- |
| TABLE OF CONTENTS |

[TABLE OF CONTENTS 1](#_Toc381566348)

[PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION 9](#_Toc381566349)

[Part B – EXECUTIVE SUMMARY 17](#_Toc381566350)

[Part C– Situation Analysis 20](#_Toc381566351)

[1. Key relevant health and health system statistics 20](#_Toc381566352)

[2. Description of the National Health Sector 23](#_Toc381566353)

[3. National Health Strategy and Joint Assessment of National Health Strategy (JANS) 25](#_Toc381566354)

[4. Monitoring and Evaluation Plan for the National Health Strategy 27](#_Toc381566355)

[5. Health Systems Bottlenecks to Achieving Immunization Outcomes 29](#_Toc381566356)

[6. Lessons Learned and Past Experience 33](#_Toc381566357)

[PART D – PROPOSAL DETAILS 35](#_Toc381566358)

[7. Proposal Objectives 35](#_Toc381566359)

[8. Results Chain 38](#_Toc381566360)

[9. Monitoring & Evaluation Plan 45](#_Toc381566361)

[10. Detailed Budget and Workplan 47](#_Toc381566362)

[PART E – BUDGET, GAP ANALYSIS AND WORK PLAN 50](#_Toc381566363)

[11. Detailed Budget and workplan 50](#_Toc381566364)

[12. Gap Analysis & Complementarity 51](#_Toc381566365)

[13. Viability 53](#_Toc381566366)

[PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION 54](#_Toc381566367)

[14. Implementation Strategies 54](#_Toc381566368)

[15. Participation of civil society organizations 57](#_Toc381566369)

[16. Technical Assistance 58](#_Toc381566370)

[17. Risks and Mitigating Factors 60](#_Toc381566371)

[18. Financial Management and Procurement Arrangements 64](#_Toc381566372)

[SUMMARY OF A COMPLETE APPLICATION 70](#_Toc381566373)

ABBREVIATIONS AND ACRONYMS

|  |  |
| --- | --- |
| **US$** | US Dollar |
| **AECID** | Agence Espagnole de Coopération Internationale pour le Développement (Spanish Agency for International Development Cooperation) |
| **AFD** | Agence Française de Développement (French Development Agency) |
| **ANO** | Avis de Non Objection (Non Objection) |
| **CHW** | Community Health Worker |
| **CCC** | Communication pour un Changement de Comportement (Information influencing practices) |
|  |  |
| **ICC** | Inter-Agency Co-ordination Committee |
| **CHR** | Regional Hospital Center |
| **CNTS** | National Blood Transfusion Center |
| **CNS** | Comité National de Santé (National Health Council) |
| **MC** | Management Committee |
| **COSAN** | Comité de Santé (Health Council) |
| **CSC** | Case de Santé (Health Hut) |
| **IHC** | Integrated Health Center |
|  |  |
| **CTNS** | Comité Technique National de Santé (National Health Technical Committee) |
| **DEP** | Direction des Etudes et de la Programmation (Directorate for Research and Scheduling) |
| **DI EPS** | Division on Health Information and Education |
| **DQA** | Data Quality Audit |
| **DQS** | Data Quality Survey |
| **DQS** | Data Quality System |
| **RPHM** | Regional Public Health Management |
| **HD** | Health District |
| **ECD** | Equipe Cadre de District (District Management Team) |
| **FIC** | Immunization Coverage Survey |
| **DHSN** | National Demographic and Health Survey |
| **EPA** | Etablissement Public à caractère Administratif (Administrative Type Public Institutions (API)) |
| **F CFA** | African Financial Community Franc |
| **RBF** | Results-Based Financing |
| **FC** | Common Funds |
| **FDS** | Force de Défense et de sécurité (Defense and Security Force) |
| **SWOT** | Strengths, Weaknesses, Opportunities and Threats |
|  |  |
| **GAR** | Gestion Axée sur les Résultats (Results-Based Management) |
| **GAVI** | Global Alliance for Vaccines and Immunization |
| **DH** | District Hospital |
| **NH** | National Hospital |
| **IDE** | Infirmier Diplômé d’Etat (State Registered Nurse with Degree) |
| **IEC** | Information Education Communication |
| **IHP** | International Health Partnership |
| **MRR** | Regional Referral Maternity |
|  |  |
| **MSP** | Ministère de la Santé Publique (Ministry of Public Health – MPH) |
| **N/A** | Not applicable |
| **NTICs** | New Technologies for Information and Communication |
| **OMD** | Objectifs du Millénaire pour le de Développement (Millenium Development Goals) |
| **OMD** | Objectifs du Millénaire pour le de Développement (Millenium Development Goals) |
| **WHO** | World Health Organization |
| **ONG** | Nongovernmental Organization |
| **MMW** | Multiskilled Maintenance Worker |
| **SO** | Specific Objective |
| **CSO** | Civil Society Organization |
| **AAP** | Annual Action Plan |
| **RBF** | Results-Based Financing |
| **HDP** | Health Development Plan |
| **PENTA** | Vaccine for: Diphteria, Pertussis, Tetanus, Hepatitis B and Hib |
| **EPI** | Programme Elargi de Vaccination (Expanded Program in Immunization) |
| **FP** | Family Planning |
| **MPA** | Minimum Services Package |
| **PPAC** | Plan Pluri Annuel Complet (Comprehensive Multi-Annual Plan) |
| **TFP** | Ministry of Labor and Civil Service |
| **HSS** | Strengthening of Health Service |
| **SFDE** | Sage-femme Diplômée d’Etat (State Registered Midwife with Degree) |
| **NHIS** | National Health Information System |
| **UNS** | United Nations System |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Childrens Fund |
| **UNIPAC** | UNICEF Procurement and Assembly Centre |
| **VAT** | Tetanus Vaccine (Tetanus Toxoid) |

A completed application includes the following documents. Countries may wish to attach additional national documents as necessary (see list at the end of this form).

|  |  |  |
| --- | --- | --- |
| **HSS Proposal Forms and Mandatory GAVI attachments**  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | Health System Strengthening (HSS Program) Application, | *X* |
|  | Signature Sheet for Ministry of Health, Ministry of Finance and HSCC members | *X* |
|  | HSS Monitoring & Evaluation Framework | *X* |
|  | Detailed work plan and detailed budget | *X* |

|  |  |  |
| --- | --- | --- |
| **Existing National Documents - Mandatory Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
| 5. | National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions | *X* |
| 6. | National M&E Plan (for the health sector/strategy) | *X* |
| 7. | National immunization plan |  |
| 8. | National cMYP | *X* |
| 9. | Vaccine assessments (EVM, post-introduction assessment, EPI reviews), if available |  |
| 10. | Health Sector Coordinating Committee Mandate (HSCC) | *X* |

All applicants are encouraged to read and follow the accompanying guidelines in order to correctly fill out this form. For each section in the Guidelines, detailed instructions and illustrations are provided to assist with filling out the application form.

**GAVI’s Approach to Health System Strengthening**

The following points outline GAVI’s approach to health system strengthening and should be reflected in a HSS grant:

* One of GAVI’s strategic goals is to *“contribute to strengthening the capacity of integrated health systems to deliver immunization.”* The objective of GAVI-HSS support is to address system bottlenecks to achieve better immunization outcomes, including coverage and equity. As such, it is necessary for the application to be based on a strong analysis of the bottlenecks and gaps. present a clear results chain demonstrating the link between proposed activities and improved immunization outcomes.
* GAVI’s approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate outcomes as well as immunization outcomes such as DTP coverage, measles coverage, and % of districts reporting >80% coverage. Therefore the application must include a strong Monitoring & Evaluation framework aligned with the national M&E plan or national M&E processes.
* Results based financing is a core approach of GAVI-HSS support. All applications must align with the new GAVI *results based financing* (RBF) approach: introduced in 2012. Countries’ performance will be judged on a predefined set of RBF indicators against which additional payments will be made to reward good performance in improving immunization outcomes.
* GAVI supports the principles of alignment and harmonization (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 these guidelines.
* GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not required for a GAVI-HSS application. However, if this type of assessment has been carried out, conclusions from it can be included in a country's HSS application. The Independent Review Committee (IRC) will use the results of the JANS assessment to better understand the political context in which the health sector exists; this will inform the Committee as it evaluates the credibility and feasibility of the HSS proposal.
* GAVI recommends that a consultative and participatory approach be used for drafting the HSS proposal, and, particular, that there be cooperation between responsible departments within the Ministry of Health (for example, the planning department, the EPI, health information management systems, the entity in charge of M&E), development partners and civil society. When the HSCC (or its equivalent) is asked to sign the proposal, the ICC (or its equivalent) must also be consulted and brought into the process as the proposal is being finalized.
* GAVI encourages the countries to identify and establish links between HSS support and support for introducing new vaccines (such as GAVI support of new vaccines). These linkages must be demonstrated within the application. Countries will need to demonstrate system readiness[[1]](#footnote-1) for new vaccines to be introduced within the context of routine immunization services. GAVI-HSS support will be for strengthening these routine immunization services and country readiness for the introduction of new vaccines.
* GAVI’s approach to HSS includes support for strengthening data systems. Strong data systems are of fundamental importance both to countries and to the GAVI Alliance. Countries are strongly encouraged to include in their proposals actions to strengthen the data system, including the institutionalization of routine mechanisms to track data quality improvements over time.
* GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities to address the HSS bottlenecks to improving immunization outcomes.
* GAVI encourages applicants to include funding for Civil Society Organizations (CSOs) in implementation of HSS support to improve immunization 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 Annex 4: CSO Guidelines.
* Applications must include details on lessons learned from previous HSS grants from GAVI or support from other sources.
* Applications must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
* Applications will need to show the additionality of GAVI support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources.
* Cash disbursed for HSS support must be used solely to fund HSS Program Activities. These funds may not 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.

**The Application Process**

For more information please see the attached guidelines for completing a GAVI-HSS proposal. The application process for GAVI-HSS proposals is similar to the process for new and underused vaccines. The decision to request GAVI funding and cooperation with the Alliance partners to draft a proposal (steps 1 and 2 in Figure 1 below) will take time. When possible, these activities must be scheduled so that they coincide with the existing national planning process.

Countries are encouraged to participate in an iterative process with GAVI Alliance partners, CSOs and development partners in the development of HSS proposals prior to submission of this application for funding. Steps 1-7 indicate the standard steps for the GAVI-HSS application process. Countries should allow 9-12 months for these steps. Steps 1-3 are expected to take 3-4 months, while steps 4-7 typically take 6-9 months.

**Figure 1: The Application Process and Implementation**



|  |  |
| --- | --- |
| PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION | |
| **For further instructions, please refer to the Guidelines for Completing the HSS Application** | |
| **Applicant:** | ***MINISTRY OF PUBLIC HEALTH*** |
| **Country:** | ***NIGER*** |
| **Proposal title:** | ***HEALTH SYSTEM STRENGTHENING TO IMPROVE IMMUNIZATION PERFORMANCE*** |
| **Proposed start date:** | ***JULY 2014*** |
| **Duration of support requested:** | ***4-½ years (JULY 2014 - DECEMBER 2018)*** |
| **Total funding requested from GAVI:** | ***US$ 40.025 MILLION*** |
| **Contact Details** | |
| **Name** | ***OUSMANE OUMAROU*** |
| **Organization and Title** | ***DIRECTOR OF RESEARCH AND SCHEDULING / MINISTRY OF PUBLIC HEALTH*** |
| **Mailing address** | ***BP 623/ Niamey/ Niger*** |
| **Telephone** | ***(227) 20 20 35 29 /97 89 67 68*** |
| **Fax** | ***(227) 20 73 35 70*** |
| **E-mail** | [***Oumarou1961@yahoo.fr***](mailto:Oumarou1961@yahoo.fr) |

|  |
| --- |
| **Signatures: government endorsement** |
|  |

**HSCC / ICC SIGNATURE PAGE**

For submission with GAVI-HSS application

**Health Sector Coordination Committee**

Country**\_\_NIGER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of HSS Application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We, the members of the HSCC, or equivalent committee [1] met on \_\_\_\_\_\_\_\_\_\_\_\_ to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

**[1]** Health Sector Coordination Committee or equivalent committee which has the authority to endorse this application in the country in question.

Name of the HSCC in the country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| |  | | --- | |  | | | |  | |  |
|  | | | | | |
|  | | | | | |
| Please check the relevant box to indicate whether the signatories above include representation  from a broader CSO platform: Yes No | | | | | |
|  |  |  | |
| |  | | --- | | **For further instructions, please refer to the Guidelines for Completing the HSS Application** | | *→ Please provide an executive summary of the proposal, of no more than 2 pages, addressing the items listed below:*   1. *Objectives, key activities for each objective, and budget for each objective. The main bottlenecks for achieving immunization outcomes addressed within this proposal and how proposed objectives in this application will address these bottlenecks and improve immunization outcomes;* 2. *the goals and budget for each objective;* 3. *The proposed implementation arrangements including the role of government departments and civil society organizations. Please include a summary of financial management, procurement, and M&E arrangements. .* | | ***TWO PAGES MAXIMUM*** | | | | |

|  |
| --- |
| Part B – EXECUTIVE SUMMARY |

|  |
| --- |
| For more detailed instructions, please consult the guidelines for completing the HSS application |
| *→Please provide a summary of the proposal, not more than 2 pages in length, which addresses the following:*   1. *Goals; primary activities for each goal, and the budget for each goal.* 2. *The main obstacles to achieving the vaccination results discussed in this proposal, and the objectives proposed in this application must address the bottlenecks and constraints that exist, and must thus allow for improved vaccination results.* 3. *The proposed implementation methods including the role of governmental departments and Civil Society Organizations. Please include a financial management summary, purchases, and monitoring and evaluation methods.* |
| ***TWO PAGES MAXIMUM*** |

The GAVI-HSS grant will be administered by the Ministry of Public Health for a period of 4-1/2 years (July 2014 - December 2018) for a total of US$ 40,025,095. It is part of the 2011-2015 HDP objectives for the 2011-2015 cMYP and is specifically supporting strategic axes 1, 2, 3, 4, 6, 7 and 8. The HDP will be evaluated in 2014 a new HDP for 2016 - 2020 will be developed using this grant. An new cMYP will also be developed in 2014.

An analysis of the sector's situation highlights several bottlenecks that are impeding the health system's successes in attaining the immunization objectives. The GAVI-HSS grant will contribute to removing the following bottlenecks:

* Inadequate equitable access and the availability of high-quality basic health services base, including immunization,
* Inadequate information and awareness among the population of health problems and the low participation in health service management,
* Socio-cultural factors (taboos, religious considerations, work burden placed on women, etc.),
* Poor performance of the national health system to produce quality data in a timely manner,
* Low level of growth in healthcare research,
* Inadequate funding by the State for health care in general and for vaccination in particular,
* Inadequate M&E and coordination within the sector.

The GAVI-HSS grant will focus on removing bottlenecks in conjunction with support from the State and other partners. The grant will also be in conjunction with support from the GAVI-HSS proposal that is currently in progress, particularly with regard to aspects related to strengthening the cold chain and logistical capacity. It will support and strengthen implementation of the district micro-plans.

This grant focuses on the following five 5 objectives:

1. **Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts (US$ 30,190,984, or 75.4% of the total amount)**

To take inequity factors into account, the initiatives linked to this objective will be carried out within the 21 Health Districts selected, using the a criteria of Penta 3 lower than 80%.

Reaching this objective will be made possible by: the transformation of thirty (30) health huts into integrated health centers with human resource staffing, inputs and the equipment required to implement the MPA, support for developing and implementing district micro-plans, including the ability to achieve specific strategies for reaching the most vulnerable populations and those that are difficult to access, as well as strengthening the skills of the human resources within the health sector

These activities will allow for improved accessibility and, in turn, the availability of quality basic health services, and improved immunization coverage that is equitable.

1. **Increase demand for delivery of health service and care, and particularly, for immunization, at the national level. (US$ 4,719,759, or 11.8% of the total amount)**

Reaching this objective will be made possible by developing communication and social mobilization focused on changing behavior at the household level, opinion leaders and community health workers. The training of community health workers and support for their initiatives will contribute to the strengthening of community participation in health activities, including immunization.

These initiatives will allow for improved information, awareness and support of the population for health, and for immunizations in particular. These initiatives will also allow for improving participation by communities and CSOs in health-related activities. The use of immunization services will be increased through these initiatives.

1. **Improve the quality and use of health information and M&E activities for better strategic planning within the sector, (US$ 3,305,510, or 8.3% of the total amount)**

Reaching this objective will be made possible by the support and implementation of the strategic NHIS 2013 - 2022 Plan. Specifically: improving the availability of standardized management tools, the capacity of those involved from NHIS, improved quality of health information and increased use of data for planning and M&E of health initiatives.

All of these activities will contribute to improving the quality and the use of NHIS data, including immunization data and the taking into account of inequality factors for an improved decision-making process.

1. **Increase the State's contribution to the funding of these health activities, including immunization (US$ 141,750, or 0.4% of the total amount)**

This objective seeks to make health activities sustainable in Niger by having the State take responsibility for its leadership role by increasing its health funding contribution, consistently and efficiently.

Reaching this objective will be made possible by the lobbying by CSOs of members of parliament and other decision-makers, local governments, government-run company officials and privately-run company officials, media and the "network of advocacy champions" and following up on the State's commitments and those of partners through the COMPACT.

1. **Improve existing management mechanisms so as to implement an efficient and effective Program. (US$ 1,667,091, or 4.2% of the total amount)**

This objective seeks to improve management of the Common Funds using tools, procedures and entities for a better implementation of the Program, and do so in accordance with the Paris Declaration.

The goals is to strengthen the Common Funds capacity through the following actions:

contribution to the Common Funds operations by implementation of the HSS 2014 to 2018 activities, improving the capacity of Common Funds personnel to address financial management issues (control and audit); implementation of financial audits and controls within the framework of GAVI-HSS initiatives and activity monitoring and evaluation.

The GAVI-RSS grant will be managed by the Common Funds in accordance with its management procedures and the principles of the Paris Declaration. All acquisitions will also be made through the Common Funds' procedures. Certain equipment will be acquired through UNIPAC.

CSOs participate in initiatives through contracts. Therefore, they will be asked to participate in social mobilization activities in communities that support vaccination and where opinion leaders support it, for areas that are difficult to access or insecure. CSOs will also be involved with immunization teams where they will play an important supporting role for immunization activities. Within the framework of this proposal the budget allocated to CSOs at all levels is US$ 678,748, or 2% of the budget

|  |
| --- |
| Part C– Situation Analysis |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| For further instructions, please refer to the Guidelines for Completing the HSS Application | | | | | | | | | | |
| 1. Key relevant health and health system statistics | | | | | | | | | | |
| *→ Please complete the table below providing the most recent statistics for the key health, immunization, and health systems indicators listed.*  *→ Where possible, data on the key statistics should be presented showing wealth quintile differences, disaggregated by sex.*  *→ If available disaggregated data for the key statistics indicators showing differences by geographic location (region / province) and urban / rural should be included in the space provided after the table.*  *\*Where possible, GAVI asks for both administrative data as well as from "other" data sources. Please state the source of the "other" data in brackets after entering the value. "Other" recommended data sources are DHS/MICS or recent coverage estimates from WHO/UNICEF. If the difference between these reported data are more than 5% points, the country should include an explanation as to how they plan to strengthen data quality as part of the HSS grant.* | | | | | | | | | | |
| **Key Statistics** | | | | | | | | | | |
| **Indicator** | **Source** | | **National Average** | **Percentage difference between highest & lowest quintiles** | | **Sex**  *(Please provide disaggregated data where available)* | | | | **Year** |
| **M** | **F** | **T** | |
| Penta3 coverage | Administrative Data | | **96%** | **N/A** | | **N/A** | **N/A** | **96%** | | **2012** |
| DHSN | | **68%** |  | | **67.5%** | **68.6%** | **68.1%** | | **2012** |
| FIC | | **78%** | **42%** | | **78.0%** | **77.4%** | **78%** | | **2012** |
| Coverage for 1st dose of measles vaccine | Administrative Data | | **91%** | **44%** | | **N/A** | **N/A** | **91%** | | **2012** |
| DHSN | | **69%** |  | | **68.9%** | **68.5%** | **68.7%** | | **2012** |
| FIC | | **75 %** | **45%** | | **74.7%** | **74.7%** | **74.7%** | | **2012** |
| Dropout rate between 1st and 3rd dose of Penta | Administrative Data | | **6** |  | | **N/A** | **N/A** | **6** | | **2012** |
| DHSN | | **18** |  | | **N/A** | **N/A** | **18** | | **2012** |
| FIC | | **9** |  | | **N/A** | **N/A** | **9** | | **2012** |
| Percent of districts with PENTA3 coverage ≥80% | Administrative Data | | **98%** |  | | **N/A** | **N/A** | **98%** | | **2012** |
| DHSN | | **N/A** |  | |  |  |  | | **2012** |
| FIC | | **46%** |  | |  |  |  | | **2012** |
| PENTA3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile | Administrative Data | | **N/A** |  | |  |  |  | |  |
| DHSN-MICS IV | | **31 .8** |  | |  |  |  | | **2012** |
| Fully immunized child coverage (%) | Administrative Data | | **N/A** |  | |  |  |  | |  |
| DHSN-MICS IV | | **52.0%** |  | |  |  |  | | **2012** |
| FIC | | **63.6%** |  | | **63.7%** | **63.9%** | **63.6%** | | **2012** |
| **Additional Health System Statistics** | | | | | | | | | | |
| **Indicator** | | **Source** | | | **Value** | | | | **Year** | |
| Under Five Mortality | | DHSN-MICS IV | | | **127/1000** | | | | **2012** | |
| Mortality survival | | | **130/1000** | | | | **2010** | |
| Total expenditure on health as percentage of GDP | | Administrative Data | | |  | | | |  | |
| CNTS | | | **6.7%** | | | | **2011** | |
| Per capita expenditure on health | | Administrative Data | | |  | | | |  | |
| CNTS | | | **US$ 26** | | | | **2011** | |
| Total health sector budget for the year of application | | CNTS | | | **CFA 174,866,256,647** | | | | **2014** | |
| Other\*  Other\* (state source) | | |  | | | |  | |
| Percent of the health sector budget funded by the government from domestic sources | | Administrative Data | | | **58.27 %** | | | | **2014** | |
| Other\*  Other\* (state source) | | |  | | | |  | |
| Budget of EPI program for the year of the application | | Administrative Data | | | **CFA 17,625,637,571** | | | | **2014** | |
| Other\*  Other\* (state source) | | |  | | | |  | |
| Percent of subnational level facilities with cold chain capacities fit for purpose (based on WHO definition of “fit for purpose”) | | Administrative Data | | | **72%** | | | | **2012** | |
| Other\*  Other\* (state source) | | |  | | | |  | |
| Timeliness and completeness of center and district (or equivalent) reports | | Administrative Data | | | **Completeness 84%**  **Timeliness 52%** | | | | **2012** | |
| Other\*  Other\* (state source) | | |  | | | |  | |
| **Please use the space below to:**   * **explain possible disparities between administrative statistics and "other" statistics, and provide details about any plan focused on improving data quality to correct these disparities;** * **show statistic key indicators that are even more specific (if possible). This data will be used to illustrate equity differences by geographic location and urban/rural.** | | | | | | | | | | |
| ***THREE PAGES MAXIMUM***  The data analysis shows gaps between the administrative data and the data from other sources. The observed gaps come from what is basically a lack of adherence to the immunization schedule by mothers, lack of adherence to the interval between doses by immunization workers which causes high levels of invalid doses. To this, we must add inconsistencies in the demographic data linked to immunization from different sources and to poor management, inadequacies in the procurement of immunization supplies at the health center level, inadequacies in the supervision of quality as well as in regular decentralized monitoring for bottlenecks in health centers and health huts, and also frequent shortages of antigens at all levels. According to the results from the last immunization coverage survey (CAR-EPI 2013), the proportion of invalid doses is very high for all antigens in that it is higher than 37%. Among other reasons, it must be noted that there is also a failure to address the program target demographic of children aged 0 – 11 months. All these weaknesses are due to a lack of interpersonal communication, inadequate health coverage (47%), irregular fixed and outreach fair and mobile activities, inadequate funding for immunization activities and delay in releasing the State's portion of funds, inadequate personnel (in quantity and quality) and a lack of understanding of demographic data.  To improve data quality, the following actions will be taken and will be reinforced:   * the use of demographic data from the general population census of 2012; * training all district management teams and region health managers in data quality survey (DQS) and RED; * the state of data quality survey (DQS) monitoring since 2011 in peripheral health facilities; * Monthly meetings to clean up and standardize immunization and monitoring data; * verification of data quality during coordination meetings, quarterly and annual reviews. * Training of participants at the district and region levels at the end of 2012 on new tools and computerized immunization data management (DVD-MT and SMT); * National Health Information System (NHIS); * Reform of the NHIS and review of NHIS support completed in 2012; * Further decentralized monitoring based on equity, limited to 3 districts, * Integration of immunization coverage surveys within child survival surveys   New actions:   * Bring decentralized monitoring based on equity up to standard * Carry out bi-annual DQAs * Carry out bi-annual coverage surveys   According to DHS-MICS 2012, there is no major difference in immunization coverage between male and female children (DTP3 M: 67.5% F: 68.6%.  The same survey shows inequities between urban and rural areas (DTP3, Urban: 86.3% and Rural 64.9%), there are also significant regional disparities (DTP3 from 58.2% to 87.2%). Finally, there are strong disparities with regard to socio-economic levels (31.8 points between the richest and poorest quintiles).  The GAVI-HSS grant will take into account these inequitable factors by focusing on these activities in 21 high-priority districts and by developing specific strategies to reach difficult-to-access populations, in rural areas, nomads and insecure areas | | | | | | | | | | |

|  |
| --- |
| 2. Description of the National Health Sector |
| *This section will provide GAVI with the country context which will serve as background information during the review of the HSS proposal.*  *→ Please provide a concise overview of the national health sector, covering both the public and private sectors, including CSOs, at national, sub-national and community levels, with reference to NHP or other key documents.*   1. → Please include a copy of the National Health Strategy/Plan as Attachment 5. If the NHP is in draft format please provide details of the process and timeline for finalizing it. If there is not a NHP or other documents are referenced in this section, please provide these other key relevant documents.   *It is recommended that applicants refer to GAVI’s health systems strengthening activity categories detailed in the Application Guidelines (Table 1, "Key Terms" section). For each of the categories listed in the Guidelines (2.1-2.7) please provide a short commentary. In order to keep this section concise, please summarize the key elements in the context of the HSS support being requested, providing a reference to the relevant section in the National Health Strategy/Plan for further detail.* |
| ***TWO PAGES MAXIMUM*** |

Niger has a declaration sector health policy which is being implemented via a Health Development Plan that covers the 2011 - 2015 period.

Coordination of actions is ensured at the national level by the Ministry of Public Health that includes the Office of the MPH, a Secretariat-General, 3 General Directorates, 17 National Directorates and 16 health programs; at the regional level, there are 8 Regional Directorates of Public Health; and at the departmental level, 42 operational health districts.

**Providing services**

The health system in Niger is made up of three 3 hierarchical levels with packages of activities per level. Health services are provided by public and private health facilities, including religious ones. The public sector has 42 operational health districts with 33 district hospitals, 871 Integrated Health Centers and 2,434 operational health huts, 6 regional hospitals, 2 regional maternities for referral, 7 Mother and Child Centers and 4 regional blood transfer centers, 7 specialized centers, 3 national hospitals and one national maternity for referral.

There are 283 private service providers, 57 of which are private clinics, 36 medical offices and 5 private hospitals mainly focused on curative activities.

In addition to fixed service providers, due to inadequate health coverage (47.80%) health fairs, mobile and decentralized strategies have also been developed to reach the maximum amount of the population, and especially areas that are difficult to access and nomads. To ensure quality health services for the entire population, a referral system and a counter referral system have been put in place, supported by a processes of quality assurance and action in the health care sector.

1. **Human resources**

The health sector has human resources that amount to 12,783 workers in all categories together, which break down as follows: 1 doctor per 17,880 inhabitants, 1 nurse per 4,529 inhabitants, 1 midwife per 3,996 CBAW.

Out of all personnel, 76% are located in an urban area and 24% in a rural one. In addition to this unequal distribution throughout the country, the health system continues to suffer from inadequate Health Human Resources, quantitatively and qualitatively, due to inadequate recruitment in the public sector, inadequate ongoing training (specializations, learning internships) and a lack of appropriate mechanisms to motivate personnel.

**Health information**

Niger has a National Health Information System (NHIS) that depends on the IHC network, the health districts and the RPHM. Routine health data is produced and processed at the IHC, HD, RHC levels and in national health centers which transmit the data to Department of Statistics charged with managing health data. In addition, to monitor the implementation of health policy, periodic surveys are organized (immunization coverage every year, DHS/MICS every 4 years, child survival surveys every year, monitoring 2 times per year, satisfaction survey of beneficiaries every two years. The system also benefits from data provided by the Institut National de la Statistique (INS) gathered from different surveys as well as the general census of the population. However, the system suffers from: (1) a lack of qualified personnel and a lack of sufficient numbers of personnel, (2) inadequate support for data collection;(3) the lack of an Intranet network and the lack of computer equipment; (4) inadequate logistics; (5) a variety of support to fill out (NHIS, NGO and vertical programs); (6) the poor quality of data; (7) the inadequate quality of supervision; (8) untimely completion of data; (9) the inadequate sharing of data and (10) weak collaboration between the private and public health sectors. (11) inadequate data disaggregation.

**Community and other local actors**

* Community structures or those based in health centers for supervision and financial accountability of health services

Related to cost-recovery, for all integrated health centers and health huts, there is a management committee (COGES) in charge of managing financial revenue for services according to the rules in force in relation to the IHC health team. The system of participation is supervised by the COSAN (Health Committee) elected by the community. This method of community participation has evolved, in practice, within a limited context in relation to its conceptual framework. It has focused heavily on the financial aspects linked to cost recovery and to inventory management, but with limited power to affect the recovery margin as well as a weak commitment thank is linked to a lack of involvement by the community in local decision-making.

The external mid-term evaluation that took place for the 2005-2010 HDP highlighted the following main weaknesses of community participation:

* Non-adoption of texts drafted through community participation;
* Low participation of local territorial governments in funding health services;
* Delays in disseminating the micro-planning training guide;
* Ineffective nature of MCs and COSAN.

To offset all of these deficiencies, this system is currently being revised to be match up with the policy of free car.

* **Role of the community and civil society in service offerings**

The community, via households, participates in funding health care by: (i) paying direct fees linked to health services, (ii) contributing to the construction and housing for health workers, (iii) paying for the fuel for evacuating patients and to pay the tax collector. Communities fund the gas supply used to preserve immunizations (via cost-recovery).These methods of community participation also contribute to different immunization activities (advocacy, awareness and immunization campaigns)

Civil society, through associations, NGOs and unions participate from time to time in the funding of health care activities by creating support networks for certain vulnerable populations. Civil society also contributes to the implementation of different immunization activities (advocacy, awareness and immunization campaigns). [sic]

* **Lists of all encouragement programs (Financial or not targeted at stimulating community participation**)

There is no national program for encouraging community-level participation, however, in certain cases, such as local or regional projects and programs (WFP, BEFEN, UNFPA, etc.) diverse incentives have been developed to stimulate community participation.

|  |
| --- |
| 3. National Health Strategy and Joint Assessment of National Health Strategy (JANS) |
| *This section will be used to determine how immunization is addressed in the national health strategy, what the key findings of an independent JANS assessment of the strategy were. The Independent Review Committee (IRC) will use the conclusions from the JANS assessment to better understand the political context in which the health sector exists; this will inform the Committee as it evaluates the credibility and feasibility of the HSS proposal.*   1. → Please provide a reference to the relevant sections and pages in the NHP which outline immunization policies, objectives, and activities. 2. → If a Joint Assessment of the National Health Strategy (JANS) has been conducted, please provide the JANS report as an attachment. 3. → Please provide a summary of how the government and partners have addressed the weaknesses and recommendations identified in the JANS or attach the country’s response. |
| ***ONE PAGE MAXIMUM*** |

In Niger, the national healthcare policy is structured around the implementation of a 2011-2015 Health development plan (HDP) (Appendix 5). This policy specifically focuses on studying equity and improved accessibility for the greatest number of vulnerable individuals (women, children, populations located in rural areas, etc.)

The HDP aims to contribute to improving the health of the population, with a view toward achieving the MDGs related to the health sector. So as to be able to respond to this general objective, the specific objective assigned to HDP 2011-2015 is to offer quality health care to the population, and, in particular, to vulnerable groups.

To get closer to achieving the MDGs, the MPH has decided to focus the HDP 2011 - 2015 on improving health system management with an emphasis on reproductive health, human resource management, procurement of inputs and pharmaceutical products, the national health information system, combating HIV/AIDS, tuberculosis and malaria. And also to strengthen immunization services, a 2011-2015 Comprehensive Multi-Year Plan (cMYP) to develop the Expanded Program on Immunization has been created.

To ensure that the plan in implemented during the 2011-2015 period, eight strategic axes, as outlined below, have been defined: (1) Extension of health coverage, (2) development of quality reproductive health services; (3) providing health facilities with competent and motivated human resources, as needed; (4) permanent availability of medications, immunizations, supplies, food and therapeutic inputs, reagents, blood and blood derivatives; (5) intensification of the campaigns against diseases that are subject to integrated surveillance; (6) improved governance and leadership at all levels of the health system, (7) development of funding methods for the health sector, and (8) promotion of health research.

The HDP includes immunization among the high-impact health interventions (see pages 46, 51 and 61).

In Niger, there has not been an evaluation of the 2011-2015 HDP using the JANS tool but an evaluation occurred in a participative and inclusive fashion with all relevant parties involved, including the CSOs.

Studies and forums took place between 2011 and 2013, with all involved parties, including:

- Internal mid-term evaluation of the 2011-2015 HDP,

- National Forum on Free Care

- Etats Généraux (general meeting) on Immunization

- Health sector study

The main weaknesses of the studies and the forums that were revealed are the following: (i) the weak capacity of health workers to offer quality immunization services; (ii) the unreliability of population data used for planning; (iii) lack of supportive supervision and monitoring of immunization activities; the high number of health training (IHC and health huts) that do not offer immunization services; frequent immunization stock shortages; inadequate transport logistics (auto/motorbike) to organize immunizations; the program's heavy dependence on external funding and the poor management of funds allocated for immunization; the low coverage of nomadic populations and others that are in insecure areas; the poor performance of community actors (CHW, town criers, liaisons, immunization workers, etc.).

To correct these weaknesses, several recommendations have been identified by the Government and other partners. To address these weaknesses and recommendations, several strategies have been developed and put into place, including the adoption of the roadmap from the immunization general meeting, the revision of the minimum package of activities for health huts, the community-based strategy, the reorganization of large districts and the health financing strategy. Other strategies are being considered, specifically, offering free childbirth more often, *Results Based Financing, Universal Health Coverage, including a healthcare social fund.*

|  |
| --- |
| 4. Monitoring and Evaluation Plan for the National Health Strategy |
| *This section will provide background information on how the country organizes M&E arrangements and whether this proposal is aligned and complementary to national M&E plans.*  *→ Please attach a copy of the National M&E Plan for the national health strategy.*  *→ Please provide a summary of how the National M&E Plan is implemented in practice. In your answer refer to relevant sections of the M&E Plan for the national health strategy for further details.*  *→ Please provide a description of how development partners are involved in the M&E of the national health strategy implementation and financing. Has there been an annual joint assessment of the health sector (JAR), and if so how is it conducted? Please describe the extent of GAVI's participation and the annual joint assessment process.*  *→ Is the immunization program assessment part of the annual joint assessment? Please indicate Yes or No.* |
| ***ONE PAGE MAXIMUM*** |

Monitoring and evaluation system

The health sector has a monitoring and evaluation manual (2011-2015), a reference document for all players involved in implementing the HDP.

This manual specifies the composition, responsibilities and operations of the monitoring and evaluation entities for the HDP at the different levels of the health system. The manual determines the indicators (of which there are 45) that allow for performance within the sector to be evaluated, how they are calculated, how frequently they occur, data collection required, and its source for verification. This document integrates the objectives and indicators specific to immunization: the number of children fully immunized is set at 75% for 2015 and the rate of Penta 3 coverage is set at 95% for 2015.

The National Health Committee (CNS), chaired by the Minister of Public Health and the National Technical Health Committee (CTNS) which evaluate and validate the Strategic Plans and their Annual Actions Plans (AAP), meets one time per year, at the end of the fourth quarter of each year, and all parties involved participate at this national assembly. These two entities involve the full participation of the TFPs and the CSOs and also have representation at the district and regional levels.

At the national level, each review is made up of a joint field mission followed by the annual meetings of the CTNS and the CNS to address performance analyses of the different facilities using the AAP.

As regards scheduling, the HDP monitoring and evaluation reviews are held for each level of the health system during the first half of the year and again at the end of the year. These reviews take place with the full participation of the TFPs, government representatives, the community, civil society organizations and private entities. During these reviews, the performance of the EPI is also assessed. Even though GAVI contributes to the Common Funds, its participation is missed during the review process and would be welcome. At the peripheral health facility level, there is a quarterly performance evaluation using monitoring that supplements the district-level review and a self-evaluation by the IHCs that uses the health chart checklist.

During these reviews, AAP implementation is assessed as is evolution of the 45 HDP indicators, two of which are related to immunization (Penta3 and the number of children fully immunized). The data used to calculate these indicators are obtained from the monitoring that takes place at the health center level.

Related to immunization, the appropriate parts of the Ministry of Public Health and the ICC, with technical support from the EPI, are responsible for monitoring and evaluation of the program's performance in compliance with the indicators noted in the AAP.

At the peripheral level, the Regional Public Health Directors and District Executive Teams are responsible for performing the first level of activity monitoring as well as program performance evaluations in their respective regions and districts.

The mechanisms for monitoring and evaluation depend on NHIS, on the different sub-systems for collecting and analyzing data which have been implemented within the programs and certain surveys.

A mid-term evaluation and a final evaluation are planned for the 2011-2015 HDP as well as a JANS evaluation for the 2016-2020 HDP. At this time, a monitoring and evaluation review specific to the 2016-2020 HDP will be planned and will integrate additional essential immunization indicators.

|  |
| --- |
| 5. Health Systems Bottlenecks to Achieving Immunization Outcomes |
| *This section will be used to understand the main bottlenecks affecting health system performance. The analysis here underpins the application, ensuring the proposed activities are designed to address the bottlenecks.*  *→ Please describe key health and immunization systems constraints at national, sub-national and community levels preventing your country from improving immunization outcomes. Consider constraints to providing services to specific population groups, such as the unreached, marginalized or otherwise disadvantaged populations. The country is also asked to consider gender related barriers to accessing quality services.*  *In order to keep this section concise, please summarizes the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Strategy/Plan for further detail.*  *→ Please refer to bottlenecks which impact gender and equity-related access to immunization.*  *→ Please reference the analytical work that led to identification of the bottlenecks.*  *→ Describe the bottlenecks identified in any new vaccine proposals submitted to GAVI, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).*  *→ Which of the above-specified bottlenecks will be addressed by the current proposal? Which bottlenecks are addressed by other national or externally supported programs?* |
| ***FOUR PAGES MAXIMUM***  **1. Key health system constraints**  Identification of bottlenecks was made using the documents listed below: HDP, cMYP, Roadmap from immunization general meeting, integrated strategic communication plan, national plans for introducing new immunizations (rotavirus, pneumococcus, HPV).  The main areas that have blockages are listed below according to the level in which they have been identified:   * At the national level:   + Inadequate equitable health coverage with regard to access to quality health services;   + Inadequate human resources from both quantitative and qualitative perspectives, as well as their inequitable distribution throughout the country and their disparity between rural and urban areas.   + Districts' low use of health workers made available to them;   + Weak capacity of health information system to retain monitoring and evaluation results information;   + Inadequate support for data collection;   + Low level of growth in healthcare research;   + Under funding of sector and lack of attention given to financial protection of users and to health inequalities that exist between rural and urban areas;   + Delays in reimbursement of costs linked to free health care;   + Significant contribution by households in the funding of health care;   + Inadequate funding by the State for the purchase of immunizations and other EPI activities;   + Limited logistic capacity to ensure better management of inputs at all levels,   + Lack of storage capacity at all levels;   + Inadequate management capacity for health programs; * At the regional and sub-regional level:   + Low community involvement in health-related activities, including immunization,   + Inadequate inter personnel awareness and communication within the health sector;   + Low quality of care and services, in particular with regard to the reception by and behavior of service providers vis-à-vis patients,   + Inadequate micro-planning at the ICH level;   + Inadequate implementation of decentralized mobile activities;   + Inadequate strategies for contacting those in nomadic areas and those that live in areas that are difficult to access (far away, etc.);   + Inadequate implementation of revised MPAs in the health huts;   + Low participation by civil society organizations with regard to the implementation of health-related activities;   + Inadequate equipment maintenance management;   + Obsolete fleet of motorized vehicles;   + Inadequate medication procurement, laboratory reagents, supplies and other inputs;   + Not taking into account community data when producing reports; * A the community level:   + Low community participation in health-related activities, including immunization as well as integrated activities related to child survival;   + Socio-cultural factors (taboos, religious considerations, work burden placed on women, etc.);   Constraints specific to the introduction of new immunizations, including:   * socio-cultural factors, * inadequate immunization storage capacity, * delays in releasing the State's portion of the funds for the procurement of immunizations.   The current proposal will contribute, along with other support, to removing the following bottlenecks:  OS1   * + Inadequate equitable health coverage with regard to access to quality health services;   + Inadequate human resources from both quantitative and qualitative perspectives, as well as their inequitable distribution throughout the country and their disparity between rural and urban areas.   + Inadequate strategies for contacting those in rural nomadic areas that are difficult to access (far away, etc.);   + Inadequate implementation of revised MPAs in the health huts;   + Obsolete fleet of motorized vehicles;   + Limited logistic capacity to ensure better management of inputs at all levels;   + Inadequate medication procurement, laboratory reagents, immunization supplies and other inputs;   + Inadequate micro-planning at the ICH level;   OS2   * + Low participation by civil society organizations with regard to the implementation of health-related activities;   + Low community participation in health-related activities, including immunization;   + Socio-cultural factors (taboos, religious considerations, work burden placed on women, etc.).   OS3   * + Poor data quality and their [lack of] permanent availability at different levels;   + Inadequate support for data collection;   + Weak capacity of health information system to retain monitoring and evaluation results information, specifically as related to immunizations.   OS4   * + Inadequate budget allocated to health by the State, specifically with regard to immunization;   + Under funding of sector and lack of attention given to financial protection of users and to health inequalities that exist between rural and urban areas;   OS5   * + Inadequate management capacity for health programs;   + Inadequate coordination within the sector;   The bottlenecks below are addressed through other programs (Policy on Free Healthcare, universal health coverage , reforms related to the management of human resources, reforms of the national health Information system, etc.):   * + Delays in reimbursement of costs linked to free health care;   + Districts' low use of health workers made available to them;   + Significant contribution by households in the funding of health care;   + Not taking into account community data when producing reports.   References related to the analysis that supports the proposal are:   * for the Plan to introduce the rotavirus and pneumococcus immunizations into Niger's routine EPI in the “institutional health framework” section, on pages 12 and 13, respectively * for the HDP in the chapter “summary of major difficulties and constraint” on pages 42 and 43 * for the cMYP in the chapter “analysis of the SWOT situation” on pages 40 to 59 * for the Roadmap from the general meeting on immunization in the pages 6 to 13 * for the Integrated Strategic Communication Plan in the "Situation Analysis" on page 16 |

|  |
| --- |
| 6. Lessons Learned and Past Experience |
| *This description will highlight to GAVI how lesson-learning has been incorporated into the design of the activities. This description will include the support documents which show that the proposed activities will be effective and that by implementing them, intermediary and final results related to immunization will be anticipated.*  *→ Please use the table below to summarize the support documents and/or the lessons learned as they relate to each objective within the proposal. Applicants are requested to provide specific examples from their country, of similar initiatives that have been successful, as well as examples illustrating challenges to successful implementation.*  *→ In addition, please provide examples that illustrate the obstacles that impede a successful implementation. If no evidence base exists within the country of question, please note "not applicable".*  *\*Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to each example.* |
| *TWO PAGES MAXIMUM*  The lessons learned, particularly in relation to the implementation of GAVI-HSS 2011 include:   |  |  | | --- | --- | | *Objective* | *Lessons were learned from the results of the internal mid-term evaluation for the 2011-2015 HDP and the survey of national immunization coverage, stratified by district (MPH-January 2013), highlighting successes and was challenges.* | | *Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts.* | * *Support, development and implementation of IHC micro-plans has shown convincing results with regard to improved health and immunization coverage in particular.* * Extending immunization services to health huts (by providing cold chain and inputs) and the transformation of health huts into IHCs allow for improved access to health care including immunization services as well as reductions in operational costs linked to mobile and fair activities; * Niger has developed specific strategies (health fairs and integrated mobile activities) to reach populations that are difficult to access and nomads; these strategies have been show to be effective. * considering cost and gas procurement challenges as well as poor electrical coverage, the Government of Niger has implemented a replacement plan for the cold chain, to use solar refrigerators that do not use batteries; | | *Increase demand for delivery of health service and care, and particularly, for immunization at the national level.* | * Commitments by opinion leaders (traditional chiefs and religious leaders) and CSOs, formalized via partner contracts, have been shown to be an effective means by which to involve the population in health-related activities, including immunization; * Community monitoring of immunization coverage allows for improved efficiency and for verification of the regularity with which outreach and mobile strategies are carried out; * Negotiation the teams' immunization schedules with the parents facilitates community involvement in the immunization process; | | *Improve the quality and use of health information and M&E activities for better strategic planning within the sector* | * *Adopting DQS for key HDP indicators will allow for improvements to the quality of data found in the National Health Information System in a more integrated fashion,* * *Holding periodic programming-related and sector reviews in which the regions, TFPs, communities and CSOs participate allows the system's operational constraints to be identified as well as corrective measures* * *Understanding the dashboard health indicators at the IHC level improves health teams' self-evaluations and leads to prompt decision-making* | | *Increasing the State's contribution to the funding of these health activities, including immunization.* | * *The sub-regional experience shows that the "network of advocacy champions encouraging adequate funding" has been effective in mobilizing resources who support health.* * media and civil society involvement has proven its ability capacity to influence political decision makers to support health-related activities. | | *Improve existing management mechanisms so as to implement an efficient and effective Program* | * *The implementation of interventions via the program (Common Funds) facilitates the execution of activities and allows for short-term and long-term results to be reached.* * *Regular controls and audits of facilities and programs within the framework of the Common Funds provides a way to measure management improvements;* * *Lessons learned from the implementation of the Common Funds shows the need to improve beneficiaries' information/awareness using the procedures manual and communication/coordination from different players* * *To remove cumbersome procedures related to awarding public contracts, the government decided to eliminate the Directorate General for Public Contract Audits. In a related vein, it is preferable that procurement for the cold chain, vehicles and specific EPI inputs for the GAVI-HSS grant be made using UNIPAC through the Common Funds.* | |

|  |
| --- |
| PART D – PROPOSAL DETAILS |
|  |
| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 7. Proposal Objectives |
| *This section will be used to assess whether the proposed objectives are relevant, appropriate and aligned with the National Health Strategy and cMYP, and contribute to improving immunization outcomes. It will also ensure alignment with the bottleneck analysis above.*  *→ Please succinctly describe the immunization and HSS objectives to be addressed in this proposal and explain how they relate to, and contribute to, reducing HSS and immunization bottlenecks (identified in section C.5 above) and strengthening of the health system. Please describe how these objectives are aligned with those in the national health strategy and cMYP.*  *The objectives need to be aligned and numbered in the same way in the HSS M&E Framework (Attachment 3) and also in the detailed Budget, Workplan and Gap Analysis Template (Attachment 4).*  *For each objective, please describe:*   1. Which immunization outcomes will be improved by implementing the activities and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain. 2. *Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis and how the objectives will result in narrowing the equity gap in immunization coverage and contribute to reaching the unreached, under-served and marginalized populations? Countries are requested to consider gender related and geographic barriers to access of immunization and other health services.*   *→ Please list and describe all of the proposed activities in the Budget, Workplan and Gap Analysis Template. If the GAVI funding is requested to be put into a mechanism [sic].*  *This description will be used to assess if the proposed key activities will be sufficient to achieve the identified immunization outcomes.* |
| ***TWO PAGES MAXIMUM***  Objective 1: **Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts** (the Budget is US$ 30,190,983 or 75.4% of the total budget).  To take inequity factors into account, the initiatives linked to this objective will be carried out within the 21 Health Districts selected, using the a criteria of Penta 3 lower than 80% (see annex justifications for Priority DS):  Reaching this objective will be made possible by: the transformation of thirty (30) health huts into integrated health centers with related equipment; updating the cold chain; organization of fair-based strategies, outreach and mobile strategies, and the development of a specific strategies for nomadic zones and those that suffer from insecurity; improved human resource capacity; implementation of supervision; and, support, development, and implementation of micro-plans. The large investment for transforming health huts into IHCs with related equipment, once complete, will allow for cost reductions in mobile and outreach strategies. The amount for the cold chain will result in lower recurring charges.  This objective will contribute to removing the bottlenecks noted above (see OS1, Page 30).  Objective 2: **Increase demand for delivery of health service and care, and particularly, for immunization at the national level. (**the Budget is US$ 4,719,759, or 11.8% of the total budget).  Reaching this objective will be made possible by developing communication and social mobilization focused on changing behavior at the household level, opinion leaders and community health workers, and by surveys of attitudes and practices related to immunization. The training of community health workers and support for their initiatives will contribute to the strengthening of community participation in health activities, including immunization  This objective will contribute to removing the bottlenecks noted above (see OS2, Page 30).  Objective 3: **Improve the quality and use of health information and M&E activities for better strategic planning within the sector,** (the Budget is US$ 3,305,510.4 or 8.3% of the total budget)**.**  Reaching this objective will be made possible by support for implementing the strategic NHIS plan for 2013-2022; the data quality audits, surveys and monitoring and evaluation.  This objective will contribute to removing the bottlenecks noted above (see OS3, Page 30).  **Objective 4: Increase the State's contribution to the funding of these health activities, including immunization** (the Budget is US$ 141,750.0 or 0.4% of the total budget).  This objective seeks to make health activities sustainable in Niger by having the State take responsibility for its leadership role by increasing its health funding contribution, consistently and efficiently.  This objective will contribute to removing the bottlenecks noted above (see OS4, Page 30).  **Objective 5: Improve existing management mechanisms so as to implement an efficient and effective Program** (the Budget is US$ 1,667,091, or 4.2% of the total budget).  This objective seeks to improve management of the Common Funds using tools, procedures and entities for a better implementation of the Program, and do so in accordance with the Paris Declaration.  This objective will contribute to removing the bottlenecks noted above (see OS5, Page 30). |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 8. Results Chain | | | | | | | | | | |
| *This description will detail to GAVI how the proposed activities will result in improved immunization outcomes.*   1. → Please present a Results Chain using the template provided in the application form for each objective. This diagram should demonstrate how activities contribute to achieving outputs / intermediate results and how outputs/intermediate results contribute to achieving immunization outcomes. The medium-term outputs/results should directly link the bottlenecks identified in section 5, and should examine or help resolve bottlenecks selected for the GAVI/HSS proposal. 2. For each objective, please indicate four of five activities which are essential to achieving the mid-term and final results related to immunization. It is not required that all activities for each objective be mentioned. → The Results Chain should be consistent with the HSS M&E Framework. 3. → The results chain must be compatible with the HSS M&E framework. For every output / intermediate result and immunization outcome listed in the Results Chain there should be corresponding indicator(s) in the HSS M&E Framework to measure achievement. 4. → Please note that a GAVI HSS proposal must include the six immunization outcome indicators listed in the Guidelines Key Terms Section. Applicants are encouraged to include other relevant vaccination outcome indicators as well, if they specifically relate to the part of the health system where the funds will be used. 5. → Every mid-term or final outcome related to the results chain must have a corresponding indicator within the monitoring and evaluation plan. | | | | | | | | | | |
| **Objective 1: Objective description: Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts** | | | | | | | | | | |
|  | **Key activities:**   1. Extend health coverage by transforming health huts into IHCs, 2. Support the implementation of specific strategies (mobile and fairs) to contact difficult-to-access populations, 3. Improve logistics (vehicles and equipment) as well as the cold chain, 4. Improve skills of health sector personnel, 5. Support development and implementation of AAPs and district/IHC micro-plans. | |  | | **Outputs / Intermediate outcomes:**  Basic health services, including immunization, are available    Improved equity with regard to geographical accessibility to basic health care services, including immunization, in the 21 health districts.  Improved quality of health care services, including immunization, in the 21 health districts. | |  | **Immunization outcomes:**  **The amount of the population that has access to immunization services using national immunization strategies (fixed, outreach and mobile) has increased;**  **Improved socio-economic equity with regards to immunization coverage;**  **The rate of children who are fully vaccinated has improved.** | |  |
| **Objective 2: Objective description: Increase demand for delivery of health service and care, and particularly, for immunization at the national level.** | | | | | | | | | |  |
|  | **Key activities:**   1. Improve involved parties' skill level with regards to communication and social mobilization 2. Implementation advocacy, social mobilization and communication activities to change behavior 3. Increase community participation in health-related activities, including immunization 4. Implement operational research activities | |  | | Outputs / Intermediate outcomes:  The population is better informed/aware and participate more often in immunization activities  The health committees' participation in immunization is effective  Community health workers participate effectively in immunization activities. | |  | **Immunization outcomes:**  **The number of parents who are not aware of or who have a negative view of immunization is reduced;**  **The dropout rate is reduced.** | |  |
| **Objective 3:Objective description: Improve the quality and use of health information and M&E activities for better strategic planning within the sector** | | | | | | | | | |  |
|  | Key activities:   1. Improve NHIS actors' capacity 2. Standardize/update management tools 3. Support the use of ICT by NHIS 4. Improve data quality and use 5. Support sector reviews, the implementation of specific surveys and the development of strategic documents and funding proposals | |  | | **Outputs / Intermediate outcomes:**  **Quality health information is available** | |  | **Immunization outcomes:**  **Improvements to the timeliness and \completeness of immunization data;**  **The gaps between immunization data from different sources are reduced (Administrative, NHIS and ECV)** | |  |
| **Objective 4:Objective description: Increasing the State's contribution to the funding of these health activities, including immunization.** | | | | | | | | | |  |
|  | **Key activities:**   1. Intensify the advocacy activities targeted at opinion leaders and decision makers. 2. Strengthen collaboration with other related sectors. 3. Strengthen the monitoring of financial commitments by the State and partners and the implementation of the National Compact. | |  | | **Outputs / Intermediate outcomes:**  **The State's contribution to funding traditional and new immunizations is effective.**  **The funding of health services by the State budget, local governments and individuals continues to grow.** | |  | **Immunization outcomes:**  **The State's portion of funding for the procurement of immunizations is increased.**  **Availability of vaccines is improved.** | |  |
| **Objective 5:Objective description: Improve existing management mechanisms so as to implement an efficient and effective Program** | | | | | | | | | |  |
| **Key activities:**   1. Contribute to the operation of the Common Funds for the implementation of HSS activities from 2014 to 2018; 2. Strengthen Common Funds financial management personnel skills (control and audit); 3. Carry out financial audits and controls for GAVI-HSS interventions | |  | | **Outputs / Intermediate outcomes:**  Financial monitoring reports are available within the stated deadline,  Program implementation reports are available within the stated deadline,  Program activities are implemented within the required deadlines. | |  | **Immunization outcomes:**  **Physical and financial implementation rates are improved.** | |  |
| ***IMPACT: Please provide a description of the impact and one or multiple indicator(s)***   * Contribute to reduction of the under-five mortality rate   Infant and juvenile mortality rate per 1000 live births  Under-five mortality rate per 1000 live births in rural areas | | | | | | | | | |

|  |
| --- |
| ***ASSUMPTIONS AND RISKS:*** |
| ***THREE PAGES MAXIMUM*** |

**ASSUMPTIONS**

* Political stability is maintained;
* Security is guaranteed throughout country.
* Communities support, and accept being involved in the programs and projects;
* The TFPs contribute financially;
* Civil society as a whole participate effectively in the program's implementation;
* Good governance and rigorous management of resources within the health sector;
* Improved health personnel recruiting and low turnover for health workers at dispensaries;
* Availability of an HDP and an integrated monitoring and evaluation plan that covers the proposed period for GAVI/HSS.

**RISKS**

**General risks**

**The main risks are:**

* Political and institutional instability: This is defined as unjustified change of those in charge at the MPH (Minister, Secretary Generals, Technical Directors and Program Coordinators), leading to a state of perpetual starting over again with regard to the implementation of activities,
* Residual insecurity: Such insecurity hinders accessibility to health services, limits health worker movement needed to implement fair-related and mobile activities with the affected zones,
* Onset of epidemics and natural disasters: Niger experiences several cyclical types of epidemics (measles, meningitis, cholera, etc.) which, from their onset, cause additional work, and as a consequence, the cancellation of activities, including immunization-related ones. Furthermore, the consequences of climate events, such as floods, food and nutritional crises cause massive displacements within the population. This would make it difficult to reach certain targets,
* The parties involved (TFPs and the Government) failing to honor their commitments: This means delays in releasing funds and a lack of funds made available to health services for the implementation of activities. This impacts the implementation of activities and specifically those related to immunization.
* The population's weak economic power can influence how often they use services.

**Specific risks can compromise the ability to achieve results**:

* Personnel's availability and motivation: Inadequate health human resources, poor distribution of these resources as well as low motivation personnel strikes impact service availability by impeding the execution of activities and leading to lost opportunities for immunization activities,
* Inadequate antigen inventory and stock disruption: This interferes with availability and service offerings, including immunization. When this situation occurs, this can lead to periods of disruption in the immunization process; as a result, immunization indicators decline and there may even be the onset of an epidemic.
* Inadequate or lack of funding for alternative strategies to access health care services: inadequate or lack of funding alternative strategies to access health care services [sic] (outreach, fair and mobile) limit equitable access and geographic accessibility to health services, including immunization,
* Inadequate, or even no, funding for the training of personnel and other inputs: This can affect the quality of health services and care offered, including immunization,
* The persistence of traditional practices harmful to health and socio-cultural factors: There is a risk that the population will not support immunization activities. This is one of the leading causes for parents refusing immunization as well as for the dropout rate. Furthermore, these factors can prevent community participation in health-related actions,
* The lack of funding for implementation of the strategic NHIS plan: The recent review highlighted underfunding of the 2013-2022 strategic NHIS plan. The persistence of underfunding risks compromising expected results,
* The lack of qualified personnel for health data management: The persistence of shortages and inadequate recruitment of specialized personnel creates a risk for health data management,
* Inadequate funding efficiency for State and local government funding: The lack of ability to mobilize internal resources within the State and local governments, made worse by cash flow issues as well as the slow pace of administration with regard to the execution of public expenditures are the risks at the root of the challenges to effective funding for immunization procurement. This recurring situation causes immunization stock shortages that impede improved immunization coverage,
* Inadequate management of the proposal's implementation: Fraud, corruption, delays to the release of funds, the slow pace with which requests for proposals related to the procurement of goods and services are addressed, and delays in approving AAPs by the Common Funds' partners are risks that can affect the ability to achieve results. Furthermore, the lack of understanding of administrative, financial and accounting standards and norms by those in charge of funds management creates a risk that can impede proper implementation of the proposal.

.

|  |
| --- |
| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 9. Monitoring & Evaluation Plan |
| *GAVI will use this description to evaluate how the program's performance will be monitored and to ensure harmonization with national monitoring and evaluation methods. The proposed monitoring and evaluation plan for the HSS grant must be linked to the results chain proposed. Please provide an HSS grant Monitoring & Evaluation Framework as Attachment 3 (please complete the GAVI template).*  *→ Please provide a description of how the monitoring and evaluation will be carried out for the grant, in annex 3 (please complete the GAVI template).*  *→ Please provide a description of how the monitoring and evaluation activities will be carried out for the grant, indicating how M&E is aligned with the national health strategy results framework.*  *→ Which sources of data will be used?*  *→ How much budget will be allocated to M&E of this grant?*  *→ Please describe the M&E systems strengthening activities to be funded through this proposal.*  *→ Please identify one or multiple result(s) for immunization for each objective. These will be used for results based financing (see figure 2, page 7).*   1. → Please identify several intermediate results indicators for each objective within the grant; these will allow for tracking of the grant's overall implementation progress (they will be used for the programmable section related to RBF, see figure 2, page 7). These are the same intermediate outcome indicators that were included in the results chain in Section D.8.   *Please note that GAVI strongly recommends that each proposal includes an end of grant evaluation in their M&E Framework.* |
| ***TWO PAGES MAXIMUM*** |

The monitoring and evaluation system for GAVI-HSS support depends on the entities and mechanisms that exist within the Ministry of Health. It is integrated into the M&E 2011-2015 HDP plan.

This manual specifies the composition, responsibilities and operations of the monitoring and evaluation entities for the 2011-2015 HDP at the different levels of the health system. The manual determines the indicators (of which there are 45) that allow for performance within the sector to be evaluated, how they are calculated, how frequently they occur, data collection required, and its source for verification.

This document integrates the objectives and indicators specific to immunization: the number of children fully immunized is set at 75% for 2015 and the rate of Penta 3 coverage is set at 95% for 2015.

These monitoring and evaluation entities and mechanisms for the GAVI/HSS program

The entities:

These are health committees and technical health committees at all levels within the health system.

At the district level: Health hut and IHC health committees hold monthly meetings and district health committees meet every three months.

At the regional level: (RPHM): regional health committees and technical health committees meet every six months.

At the national level: The national technical health committee meets annually.

In addition, the committees described above have coordination meetings at the district, regional and national levels to evaluate the data availability and quality.

Furthermore, entities described in the HDP include the ICC which reviews issues specific to immunization and have monthly joint meetings that bring together the MPH and technical and financial partners within the health sector.

The mechanisms:

Monitoring and evaluation depends on immunization indicators created from data collected at the health facility level by different individuals in charge. Data collected will be used to create monthly reports. Monthly reports created by the IHCs are compiled into quarterly reports and transmitted to the health district level. These reports are reviewed and analyzed by those in charge of epidemiological surveillance and then submitted to the district coordination meetings before being transmitted to the regional level.

The regional level uses the health programming and information service to carry out a first level of audit before sending them to the Department of Statistics within the deadline specified. After being audited, the Department of Statistics compiles the data to draft the statistics yearbooks which are then disseminated to all levels.

In addition to the statistics yearbooks, there are other HSS monitoring and evaluation tools, including the program implementation reports, the financial monitoring report and the immunization coverage survey reports. To this are added the missions to monitor the implementation of HSS activities from 2014 to 2018 in the field, EPI reviews, the mid-term evaluation that takes place during the eighteenth month and the final evaluation at the end of the program.

The program implementation reports and the financial monitoring report are produced every six months through the Directorate for Research and Scheduling and the Directorate for Financial Resources and Equipment within the Ministry of Public Health.

The immunization coverage survey reports (ECV) are produced every two years under the supervision of the EPI and the Statistics Department.

Coordination of monitoring and evaluation for the HSS program is carried out by the (Directorate for Research and Scheduling.

The HSS monitoring and evaluation indicators are those that are included in the monitoring and evaluation plan (see Excel sheet). These indicators verification sources are located within the reports from the different levels mentioned above(Statistics Yearbook, program implementation reports, financial monitoring report and immunization survey reports).

|  |
| --- |
| 10. Detailed Budget and Workplan |
| *This section provides an overview of the proposal development process, emphasizing the contributions of the primary stakeholders.*  *→ Please address all points listed below. If any of these are not applicable, please indicate this and explain why:*   1. *the main entity that led proposal development and coordinated contributions; it is possible to have several main implementation entities, nevertheless, the country must decide which department will lead the process of proposal development;* 2. *the role played by the HSCC and the ICC;* 3. *cooperation between the EPI and other departments within the ministry of health who have participated in drafting the proposal;* 4. *Participation of entities below the national level (provincial, district, etc.);* 5. *the role of CSOs. Applicants must note if the HSCC/ICC has worked with a CSO platform/coalition, or only with individual organizations; please provide the name of the relevant CSOs or CSO platforms;* 6. *the names and roles of other development partners or donors;* 7. *The role of the private sector, if applicable;* 8. *a description of technical assistance received during the drafting of this proposal; include the source of technical assistance and feedback on the quality and usefulness of this technical assistance;* 9. *a description of the global development process of the proposal: duration, main stages, analytical work performed, links between preparing the proposal and the planning/budgeting for the national health sector, links between preparing the proposal and the JANS evaluation, if applicable;* 10. *a description of the most challenging issues during the preparation process, and the manner in which these were resolved.* |
| ***TWO PAGES MAXIMUM***  *When developing the proposal, a pilot committee led by the Directorate for Research and Scheduling was created, be ministerial decree of the Ministry of Public Health. The committee is made up of managers from the different technical departments within the Ministry of Public Health (planning, EPI, DIES, DSME,DSRE, HRD, HD, etc.), within the Ministries in charge of Planing, Finance, and within technical and financial partners (WHO, UNICEF, UNFPA, etc.), within members of NGOs and civil society (the network of organizations and associations, unions and the Order of Doctors in the health sector as well as international NGOs).*  *Technical assistance was solicited from WHO Niger that allowed the committee to benefit from the support of an international expert during a workshop that was very participative and inclusive and which increased members' skills and helped to reframe the proposal. The workshop took place from 29 July to 02 August 2013; a take-away from this workshop was a roadmap to assist with completing the work at hand. After the workshop, different observations were taken into account.*  *The small committee received a visit from the joint WHO, UNICEF, GAVI mission. The mission remained in Niger from the 26th of November to the 29th of November, 2013. This mission was informed of the progress made by the committee. Upon its return, the mission came up with amendments and comments that would improve this document.*  *The committee also benefited from the support of technical assistants from the 2nd of September to the 6th of September, 2013 and then again from the 20th of January to the 23rd of January, 2014, to finalize the proposal.*  *Then the proposal was sent for review by the MPH-TFP coordination meeting for the sector, chaired by the Minister of Public Health on 14 January 2014, for comments. Another meeting of the coordination group was held on 20 January to validate the proposal.*  *The small group met from the 20th of January to the 24th of January, 2014 to integrate the comments made during the validation meeting of 20 January.*  *Furthermore, during some of the meetings, planning began for the large number of regional and sub-regional facilities within the MPH that will be created under the current request. The committee also conducted discussions via email to further refine this document.*  *To draft the proposal, the committee carried out an analysis of the health situation through review of documentation, interviews, the Internet. The purpose of this was to identify the problems and needs of the population so as to better determine the different areas of intervention. Then, priority objectives were chosen as was the order of activities. The preparatory work allowed for the budget to be refined for all the activities selected, using a timeline for execution.*  *The challenges experienced during the development of this proposal were addressed, mainly:*   * *the unavailability of certain data that would allow for physical and financial gaps to be better defined;* * *inadequate resources that are required for optimal operations of the technical committee that develops the proposal.*   *The process of creating this request lasted eight (8) months, beginning in June 2013.* |

**PART E – BUDGET, GAP ANALYSIS AND WORK PLAN**

|  |
| --- |
| 11. Detailed Budget and workplan |
| *This description will allow for the budget to be evaluated if the proposed budget sufficiently justifies the activities proposed and the costs of the activities within the framework of the HSS grant.*   1. → Please provide a budget and a detailed work plan as attachment 4 to this proposal. → It is strongly recommended that the template for the GAVI-HSS Budget, Work plan & Gap Analysis be used. In addition, the countries may also provide this information as an existing annual operational plan or equivalent document.   *→Please include additional information on the applications as related to the budget and justify unit costs to show that they are reasonable and supported by planning at the national level. These applications and justifications of unit costs may be included here or attached as separate documentation.* |
| ***TWO PAGES MAXIMUM***  This proposal includes ninety-nine (99) activities for an estimated total of forty million, twenty-five thousand and ninety-five (US$ 40,025,095) US dollars, of which US$ 1,667,091, or 4.2% are for the management of the proposal.  Detailed budgets in GAVI's format with financial gap analysis are included in the annex. The procedure used to select activities corresponds with the methodology defined above. The amount for each activity is defined using unit costs with different variables that are relevant to its implementation.  The unit costs used to develop the budgets have been established using:   * The procedures manual for the Common Fund; * The national price list for supplies and services; * The UNICEF/WHO database for vehicles, cold chain and EPI-specific equipment, supplemented by UNICEF management costs, as well as costs for supply chain management, transport and installation.   The following table shows the overall budget, showing absolute and relative values and per objective   |  |  |  | | --- | --- | --- | | Objective | Amount ($US) | % Total | | 1 | 30,190,983.7 | 75.4% | | 2 | 4,719,759.4 | 11.8% | | 3 | 3,305,510.4 | 8.3% | | 4 | 141,750.0 | 0.4% | | Sub-total | 38,358,003.5 |  | | Proposal management (Objective 5) | 1,667,091.0 | 4.2% | | Grand TOTAL | 40,025,094.5 |  |   **It is important to specify that additional RBF-GAVI funds will be used, if received, for Objective 1, to strengthen mobile and fair activities as well as update cold chain equipment** |

|  |
| --- |
| 12. Gap Analysis & Complementarity |
| *This description will ensure that GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication. This will also highlight the value added of the support asked of GAVI.*  *→ Please complete the gap analysis tab in the GAVI-HSS Budget, Work plan & Gap Analysis Template. This Gap Analysis should be linked to each of the proposal's objectives, to clarify the total amount of resources need to strengthen the health system related to this objective, and the different funding resources from HSS that are already in place, such as those that appear on the national health sector strategy/plan, cMYP or other gap analyses that have been performed.*  *→ For each objective, the candidates will prepare the list of different HSS funding resources already in place that contribute to the proposal objective, including Government and external donors' grants, the name of the project, as applicable (or indicate budget support), the duration of the support, the funding amount provided in US Dollars and the geographic zone covered by the support.*  *→ In the box below, please describe other activities undertaken by the Government or its development partners which focus on the bottlenecks targeted by the proposed objectives, in particular, the calendar and geographic zone of the support, highlighting the value added of GAVI support and the manner in which the current proposal complements these activities.* |
| **TWO PAGES MAXIMUM**  The gap and complementarity analyses depend on the total resources required per objective which were estimated using the 2012 - 2013 AAP financial projections for the 2014 - 2018 period.  The estimate of the government's grants and of resources come from external donors was established using available data from various annual action plans for the facilities concerned. The estimates for the 2014 - 2018 period were made using the 2012 - 2013 data projections.  **Objective 1: Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts**  To reach this objective, the Government of Niger will contribute to the government and technical and financial partners' efforts for the implementation of actions for which the global amount needed is estimated at US$ 235,791,237 for the 2014 - 2018 period. The resources currently available for the implementation from the State equal US$ 34,207,885. Those from the main partners, including UNFPA, UNICEF, CF, WHO, EU, Coopération chinoise and the DSF, are estimated at US$ 74,554,715, for a total of US$ 108,762,600. Therefore, there is a funding gap of US$ 127,028,637. GAVI's contribution toward reducing the gap is estimated at US$ 30,190,984.  **Objective 2: Increase demand for delivery of health service and care, and particularly, for immunization at the national level**  To increase demand for care, the health system requires total funding estimated at US$ 449,062,541 for the 2014-2018 period. To reach this objective, the resources available from the State are estimated at US$ 4,114,277. Those from the main partners, including UNFPA, UNICEF, the CF, WHO, the WAHO, and AGIR PF, are estimated at US$ 268,148,988, for a total amount of US$ 272,263,265 for the 2014 - 2018 period. GAVI's contribution is estimated at US$ 4,719,759 for a funding gap of US$ 176,799,276.  **Objective 3: Improve the quality and use of health information and M&E activities for better strategic planning within the sector**  To reach this objective, the State is expecting to be able to contribute US$ 7,703,056 for the 2014-2018 period. As for the main partners, including UNFPA, UNICEF, the CF, WHO, PAI and URC, their contribution is estimated at US$ 77,364,798.  For a total global funding need of US$ 151,545,475, there is an estimated funding gap of US$ 66,477,621. The expected GAVI contribution is estimated at US$ 3,305,510.  **Objective 4: Increasing the State's contribution to the funding of these health activities, including immunization.**  The global needs to cover these activities are US$ 345,053,216 for the 2014 - 2018 period and the expected funding from the State is estimated at US$ 85,110,000 and will be used to strengthen the free health care policy. The contribution from partners such as the WAEMU, the CF, WHO and PAI is estimated at US$ 2,330,000.  There is a funding gap of US$ 257,613,216 and the expected GAVI contribution is estimated at US$ 141,750 for the implementation of activities for advocacy directed at members of parliament, local governments, state-run companies, private companies, CSOs, the media, and the "network of advocacy champions," with the goal of mobilizing resources for health-related actions, and immunization activities specifically.  **Objective 5: Improve existing management mechanisms so as to implement an efficient and effective Program**  To strengthen the Program's management mechanism, the global need is estimated at US$ 105,463,487 for the 2014 - 2018 period. The State's contribution is estimated at US$ 10,846,062 and that of the main partners (UNFPA, UNICEF, the CF, WHO and PAI) is estimated at US$ 9,701,619. The State's and the partners' contributions together total US$ 20,547,680. GAVI's contribution within the proposal is US$ 1,667,091 for the 2014 - 2018 period, for a funding gap of US$ 84,915,806. |

|  |
| --- |
| 13. Viability |
| *This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.*  *→ Please describe how the government is going to ensure sustainability of the results achieved by the GAVI grant after its completion.*  *This should include the viability of funding immunization services and strengthening the health system, as well as the programmatic viability of results.*  *→ If there are other recurring costs included in the proposal, please describe how the country will cover these costs after support has ended.* |
| ***TWO PAGES MAXIMUM***  ***Viability of funding for immunization services and for health system strengthening,***  The actions included in this request will be maintained after GAVIs support by the efforts of the Government, local governments and the support of certain TFPs.  The health huts transformed in IHCs within health districts will be operational as soon as the transition takes place, due to the efforts of the State and the allocation of the required human resources, the implementation of inputs and the regular allocation of designated credits. Currently, more than 80% of health huts are run by qualified personnel. In addition, the MPH has a budget line item for recruiting contract personnel, which will be made available, as a priority, to the health huts transformed into IHCs (CFA 282M in 2014).  The mobile and fair health strategies are high-impact interventions the 2011-2015 HDP. They are currently carried out in all the health districts with the support of the TFPs, local governments and communities. The funding is ensured via facility annual action plans. One of this request's objectives is to increase funding for these actions and sustained support will be guaranteed by the allocation of additional resources in the State and local government budget as well as contributions from the communities.  Updates to the cold chain with solar equipment will allow for reductions in operational costs.  The State budget has a decentralized line item for equipment maintenance and logistics. In addition, local governments are involved in maintenance for these equipment via operation cards.  The national health information system has adopted a 2013 - 2022 strategic plan for which the implementation strategies are currently funded by the State and the TFPs.. This request addresses mobilization and allocation of additional resources; associated actions are also relevant to the implementation of this strategic plan. After 2018, funding for these actions will be guaranteed by resources allocated by the State and the TFPs.  The funding strategy used by the MPH develops all the ongoing actions in this request and is funded by the State, local governments and the TFPs. In addition, their sustainability will be ensured by resources from these same players.  The GAVI-HSS grant will allow, through advocacy activities for increasing health funding from the State and local governments. |

|  |
| --- |
| PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION |

|  |
| --- |
| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 14. Implementation Strategies |
| *This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that program activities will be implemented.*  *Please describe:*  *→ how will implementation of the grant be managed; identify key implementing entities and their responsibilities with regard to governance and auditing;*  *→ mechanisms which will ensure coordination among the implementing entities;*  *→ financial resources from the grant proceeds that will be allocated to grant management and implementation;*  *→ The role of development partners in supporting the country in grant implementation.* |
| ***TWO PAGES MAXIMUM***  The method of management for this proposal will be implemented via common funds management that provides support to the HDP. The management procedure manual defines this and there is a letter of understanding, adopted in collaboration with the TFPs who are involved in this funding.  Fiduciary management is conducted using a main account (national level) and around fifty secondary accounts (regional and district) which have been opened at commercial banks. The secondary accounts are funded from the main account using quarterly forecasting from the AAPs. All financial transactions are subject to dual signatures at all levels. At the national level, the signatories are the Secretary General and the Director of MPH's Financial Resources and Equipment. At the regional level, the signatories are the regional director and the administrative and financial director. At the district level the signatories are the chief doctor and the project manager. Each signatory has an alternate. At the national and regional levels, the common funds use an accounting management software (TOMPRO). At these two levels, management of funds is carried out by accountants. At the district level, this type of management is carried out by project managers who have cash and bank books. Transactions are carried out either using checks or electronic transfer.  The funds are subject to internal and external audit. The external audit occurs annually and is performed by independent auditors. The first level internal audit that takes place at the national level is conducted by a comptroller and the second level audit is conducted by an internal auditor. At the regional and district levels, the audit is carried out by a regional accountant. At the regional level, the first level audit is conducted every six months by the internal auditor from the national level. A financial monitoring report is produced each semester by the department of financial resources and equipment and the common funds.  For the HDP implementation, the health sector has the following management entities: the National Health Committee (CNS), the National Technical Health Committee (CTNS) and for coordination the MPH and the TFPs are responsible for steering the project. Implementation of this request will be executed via these entities.  Within this framework, the AAPs are drafted and submitted to the CTNS and then validated by the CNS. Once the AAPs are approved, they are executed by the different departments within the ministry of health in accordance with the HDP implementation manual and the administrative and financial procedure manual for the common funds. The action plans are evaluated during the first six months of the year and again at the end of the year. These evaluations are respectively sanctioned by an program implementation evaluation and a memorandum. These two documents are submitted for signature by the two parties--the Secretary General for the MPH and the lead partner for the TFPs.  The financial resources from this request which will be allocated to management equal US$ **1,667,091, or 4.17% and will be used to finance the following activities:**   * Contribute to the Common Funds' operations (salaries, supplies, computer equipment, fuel, logistics) * Contribute to Common Funds' financial audit costs; * Contribute to inventory costs for assets purchased with the Common Funds and for updating the database of the MPH's inventory management software; * Contribute to the funding of financial monitoring activities for the management of the Common Funds * Contribute to funding the improvement of skills for the Common Funds personnel.   → The role of development partners in supporting the country in grant implementation   |  |  | | --- | --- | | **Partners** | **Roles and specific responsibilities of the implementation partners** | | Minister in charge of Public Health | PRESIDENT of the National Health Committee (CNS) and coordination within the health sector. | | The Secretary General of the MPH; | EXECUTIVE SECRETARY OF THE CNS   * Prepare CNS/TFP meetings; * Monitor implementation of decisions; * Handle liaison between the CNS and the Regional Health Committees; * Ensure strategic HDP coordination.   PRESIDENT of the National Healthcare Technical Committee (CTNS)   * Coordinate and supervise the implementation of HSS support; * Coordinate Common Funds activities; * Signs the memorandum and implementation report | | Lead Technical and Financial Partners (TFPs) | As the lead TFP, act as an intermediary between the TFP and the MPH and facilitate communication between them. The TFPs participate in health committee meetings and coordination at all levels. They also sign the memorandum and implementation report. Jointly with the SG. | | Bring together the CSOs (NGO Associations, unions, orders, etc.) for the health sector | Actors in the health sector participate in the implementation of the HDP through social mobilization activities and advocacy of leaders and within communities. They participate in health committee meetings at all levels, in immunization activities and in strengthening the capacities of communities and community health workers. | | The private sector | Actors in the private sector participate in the implementation of activities through health service offerings at the various levels | | Local governments and communities | They participate in the mobilization of resources and the implementation of activities | |

|  |
| --- |
| 15. Participation of civil society organizations |
| *This description will be used to assess the involvement of CSOs in the implementation of the proposed activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO[[2]](#footnote-2).*   1. → Please describe if or how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.   *→ Please ensure that any CSO implementation details are reflected within the detailed budget and work plan.* |
| ***TWO PAGES MAXIMUM***  Health committees, unions, NGOs and associations within the health sector are key actors in the planned implementation of the HDP. They participate through management activities related to health centers (COGES and COSAN), through social mobilization and through advocacy of leaders and community. They participate in health committee meetings at all levels, in immunization activities and in strengthening the capacities of communities and community health workers. Members of civil society also participate every year in field visits and the supervisions organized by the MPH with the TFPs in the health sector  Regarding monitoring and evaluation of the HDP, civil society participates in this process as member of the entities at different levels within the system. They also participate with drafting and validating the different action plans at all levels.  Within the framework of the implementation of this request, CSOs participate in initiatives through contracts. Therefore, they will be asked to participate in social mobilization activities in communities that support vaccination and where opinion leaders support it, for areas that are difficult to access or insecure. CSOs will also be involved with immunization teams where they will play an important supporting role for immunization activities. The will also be directly involved in the implementation of services, governance, and community health information.  Within the framework of this proposal the budget allocated to CSOs at all levels is US$ 678,748, or 2% of the budget |

|  |
| --- |
| 16. Technical Assistance |
| *This description will outline to GAVI how technical assistance will support implementation of the proposed activities.*   1. → Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and immunization program function.   *→ Please outline how technical assistance will improve institutional capacities of government agencies and CSOs and contribute to sustainability.* |
| ***ONE PAGE MAXIMUM*** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Management and/or technical assistance **objective** | Management and/or technical assistance **activity** | **Intended beneficiary** of management and/or technical assistance | Estimated timeline | Estimated cost  *🡪 same currency as for proposal* |
| Support final 2011-2015 HDP evaluation and development of new HDP | 1. Technical assistance to support the MPH with evaluation methodology and the training of resource persons 2. Technical assistance for analyzing the situation, objectives, priority strategies and costing | DEP | 60 days | US$ 32000  (WHO,UNICEF,CTB,WB; CF) |
| Strengthen worker skills (DEP, EPI, HD, DSRE, DOS, DN, DSME) on SARA and JANS | 1. Training specific to the JANS tool 2. Technical support for the implementation of SARA request and data analysis | DEP | 30 days | US$ 16600  (WHO, COIA, IHP+, Luxembourg) |
| Support the recruitment of financial auditing firms | 1. Support for implementation of external financial and accounting audits for the Common Funds accounts | SG | 21 days per year | US$ 88890  (GAVI-HSS) |
| Support for implementation of DHIS2 | 1. Support for DHIS2 development and training administrators | HD | 30 days | US$ 16600  UNICEF, UNFPA, Luxembourg) |
| Support draft of integrated 2016 - 2020 communication plan | 1. Specific technical expertise | ID | 15 days | US$ 7800  UNICEF |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 17. Risks and Mitigating Factors | | | | | |
| *This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and spend the funds as approved by GAVI. In principal, it is the main implementing entity that will be responsible for evaluating risks and for taking measures to ensure that risk mitigating factors are truly applied.*  *→ Please complete the table below for each of the proposed objectives. Please refer to the Guidelines for Completing the HSS Application for a description of the various types of risk. If the risk is categorized as ‘high’, please provide an explanation as to why it is ‘high’.* | | | | | |
| **Description of risk** | ***PROBABILITY***  ***(high, medium, low)*** | ***IMPACT***  ***(high, medium, low)*** | | ***Mitigation Measures*** | |
| ***Objective 1:* Improve accessibility to health services including quality immunization services, specifically within the 21 high-priority health districts** | | | | | |
| *Fiduciary Risks:*  - Fraud and corruption may negatively influence the proposal's implementation (internal)  - Risk of low/slow release of funds for the request | ***Weak*** | ***Medium*** | | - Existence of an accounting and financial procedures manual for the CF  - Training, including awareness training, for actors, in the manual  - certain equipment will be acquired through UNIPAC  - Annual financial audits of the CF  - Internal audits of the CF  - strengthening activity implementation monitoring  - GAVI’S Non-objection  - strengthen CF management capacities and beneficiary management capacities | |
| *Institutional Risks:*  - institutional instability  - inadequate forecasting regarding TFP funding | ***Weak*** | ***Medium*** | | - Delegation of power to alternates  - Strengthen MPH-TFP coordination | |
| *Operational Risks:*  - Slow treatment of request for proposal for the procurement of goods and services, delays in product delivery (internal)  - Delay in AAP approval by Common Funds partners  - Inadequate recruitment of health human resources, poor distribution and excessive displacement of existing personnel (internal)  - Poor motivation of existing field personnel impedes execution of activities  (internal)  - The population's weak economic power (external) can influence how often they use services. | ***Weak*** | ***Medium*** | | Certain equipment will be acquired through UNIPAC  - Strengthen the skills of those in charge of procurement  - improve internal reorganization of CF partners to facilitate procurement  - strengthen MPH-TFP coordination  - existence of an MPH budget line item to hire contract health personnel  - decentralization of health personnel management at the regional and district levels  ***-*** existence of motivation for personnel located in difficult-to-access areas  - RBF under consideration    - Pursuing a free health policy  - Implementation of funding strategy for the health sector. | |
| ***Overall Risk Rating for Objective 1*** | ***Weak*** | ***Medium*** | |  | |
| ***Objective 2:* Increase demand for delivery of health care, including immunization at the national level.** | | | | | |
| *Fiduciary Risks:* ***see Objective 1*** | ***Weak*** | ***Medium*** | | ***same as Objective 1*** | |
| *Institutional Risks:* ***see Objective 1*** | ***Weak*** | ***Medium*** | | ***same as Objective 1*** | |
| *Operational Risks:*  ***see Objective 1***  - Persistence of traditional practices harmful to health and socio-cultural factors (external);  - inadequate capacity of CSOs to implement activities | ***Weak*** | ***Weak*** | | ***same as Objective 1***  - Strengthen awareness and advocacy activities in relation to opinion leaders,  - Extend "schools for husbands" program to all IHCs.  - Advance evaluation of CSO capacities by the district management teams before contracts | |
| ***Overall Risk Rating for Objective 2*** | ***Weak*** | ***Medium*** | |  | |
| ***Objective 3:*** Improve the quality and use of health information and M&E activities for better strategic planning within the sector | | | | | |
| *Fiduciary Risks:* ***see Objective 1*** | ***Weak*** | | ***Weak*** | | ***same as Objective 1*** |
| *Institutional Risks:* ***see Objective 1***  The lack of funding for implementation of the strategic NHIS plan | ***Weak*** | | ***Medium*** | | ***same as Objective 1***  ***-*** organization of a round table to mobilize the resources needed for 2014 |
| *Operational Risks:*   * Poor Internet coverage and operation throughout the country * The persistence of a shortage of specialized personnel in health data management | ***Weak***  ***Medium*** | | ***Weak***  ***Medium*** | | - Existence of plan to extend Internet coverage, funded by the CF  - Ongoing experiment for transmission of NHIS data using telephone data  - Recruitment and capacity strengthening of the personnel in charge of health information management |
| ***Overall Risk Rating for Objective 3*** | ***Weak*** | | ***Medium*** | |  |
| ***Objective 4***Increasing the State's contribution to the funding of these health activities, including immunization. | | | | | |
| *Fiduciary Risks:* ***see Objective 1*** | ***Weak*** | ***Weak*** | | ***same as Objective 1*** | |
| *Institutional Risks:* ***see Objective 1***  *- weak capacity to mobilize internal resources*  *- inadequate State funds* | ***Weak*** | ***Medium*** | | ***same as Objective 1***  ***-*** existence of a program to reform fiscal administration  - decentralized allocation of mining royalties | |
| *Operational Risks:*  *- slow administration for the execution of public expenditures* | ***Weak*** | ***Medium*** | | ***-*** existence of a monitoring plan for public expenditures | |
| ***Overall Risk Rating for Objective 4*** | ***Weak*** | ***Medium*** | |  | |
| ***Objective 5:* Improve existing management mechanisms so as to implement an efficient and effective Program** | | | | | |
| *Fiduciary Risks:*   * same as Objective 1 | ***Weak*** | ***Medium*** | | - same as Objective 1 | |
| *Institutional Risks:* ***see Objective 1*** | ***Weak*** | ***Medium*** | | ***same as Objective 1*** | |
| *Operational Risks:*  *- slow administration for the execution of public expenditures* | ***Weak*** | ***Medium*** | | ***-*** existence of a monitoring plan for public expenditures | |
| ***Overall Risk Rating for Objective 5*** | ***Weak*** | ***Medium*** | |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 18. Financial Management and Procurement Arrangements | | | | |
| *In this section applicants are requested to describe:*  *→ a) The proposed financial management mechanism for this proposal;*  *→b) The proposed processes and systems for ensuring effective financial management of this proposal, including the organization and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow) , procurement, accounting and financial reporting ( incl. fixed asset management), internal control and internal audit, and external audit. 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 Annex 4 of the Guidelines for further details;*  *→ c) The main constraints in the (health sector’s) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfill the above functions.*  *4 pages maximum (additional pages will be required if there is more than one main implementing entity)* | | | | |
| *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.* | | | | *The method of financial management that will be used is the method used by the Common Funds (CF) that already exist and are satisfactory, and are used by other partners of the Ministry of Public, including GAVI.* |
| **Question B: Financial Management Arrangements Data Sheet** | | | | |
| **All beneficiaries (organization/country) applying to receive direct financing from GAVI must complete this information sheet (for example the Ministry of Health and/or a CSO**  **that receives direct financing).** | | | | |
| 1. General information to be provided by the recipient organization/country. | | | | ALDJOUMA NIANDOU SAIDOU Financial Resources and Equipment BP 623, Niamey, Niger  Tel: (227) 20 20 35 66 / 96 55 19 58  Fax: (227) 20 73 35 70 |
| 1. Has the recipient organization already worked with GAVI, the World Bank, WHO, UNICEF, or the Global Fund for the prevention of AIDS, tuberculosis and malaria or other development partners and has it already received grants? | | | | Yes |
| 1. **If YES**  * Please provide the name and amount of the grant, as well as the years awarded. * **For completed GAVI grants and other development partners:** please briefly describe the main conclusions related to the use of these funds from a financial management outcome. * **For ongoing GAVI grants and other development partners:** please briefly describe any financial management or procurement problems (for example, ineligible expenses, out-of-the-norm purchases, misuse of funds, late account audit reports, and account audits that showed reserves). | | | | **31 December 2011**:   * AFD 9,721,071,072 FCFA or US$ 19,442,144 * AECID 3,35,42,00 FCFA or US$ 7,871,484 * GAVI: 212,242,483 FCFA or US$ 424,485 * UNICEF: 230,241,000 FCFA or US$ 460,482 * World Bank: 17,294,433,754 FCFA or US$ 34,525,868   **2012**   * AECID: 1,967,871,000 FCFA or US$ 3,937,742 * AFD: 3,279,785,000 FCFA or US$ 6,559,570 * UNICEF: 500,000,000 FCFA or US$ 1,000,000 * GAVI: 1,954,916,903 CFA or US$ 3,909,834   **2013**   * AFD: 3,279,785,000 FCFA or US$ 6,559,570 * UNICEF: 500,000,000 FCFA or US$ 1,000,000 * GAVI: 498,681,525 FCFA or US$ 997,363   *For allocations in progress, GAVI and other development partners, there are no problematic issues for financial management and the procurement process. The current state of the Common Funds ensure efficient financial management.* |
| **Oversight, Planning and Budgeting** | | | | |
| 1. Which entity will be responsible for in-country oversight of the program? Please briefly describe membership, meeting frequency as well as decision making process. | | | | *the National Health Committee: is made up of technical managers, political leaders, administrators, traditional leaders, TFPs, community representatives, private health facilities as well as civil society and partner ministries. The committee meets on a annual basis. Decisions are made by consensus and, if needed, by vote.* |
| 1. Who will be responsible for annual GAVI-HSS planning and budgeting? | | | | *The DEP is, in collaboration with the different facilities concerned at the national level and decentralized* |
| 1. What is the planning & budgeting process and who is responsible for approving the annual GAVI-HSS work plan and budget? | | | | *Every year, the facilities submit their AAPs (Budgets) to the technical health committees (at the district, regional and national levels) who, in turn, review them and submit them to the CTNS and the CNS for approval.* |
| 1. Will the GAVI-HSS program be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval? | | | | ***Yes:*** *The entire MPH budget, including what is contributed by the TFPs is submitted to parliament for approval, subject to the laws on funding. Contributions by the TFPs are included and show as investments.* |
| **Budget Execution (incl. treasury management and funds flow)** | | | | |
| 1. What is the suggested banking arrangement (for example, SWAp, budget support or pooled funding)? Please provide the list of the authorized signatories for the release of funds and all requests for additional funds. | | | | *The special Common Funds (CF) account is at a local commercial bank and funded two times per year in Francs CFA; this account is used to, in turn, fund the secondary accounts on a quarterly basis.*  *Authorized signatories for the release of funds and all requests for additional funds are:*  *The Common Funds Coordinator (the Secretary General of the MPH) and alternate (the MPH's Under-Secretary General),*  *The Director of the Department of Financial Resources and Equipment (DRFM) and alternate, the Head of the Finance and Accounting Division.* |
| 1. 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? | | | | *YES: GAVI-HSS funds will be transferred to the CF account which is a special account open in a local commercial bank--the BIA.* |
| 1. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors - a “pooled account”)? | | | | *The special CF account is funded by only funds that are from following TFPs: AFD, AECID, UNICEF and GAVI.* |
| 1. 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. | | | | ***Yes:*** *An account is opened in CFAF in a commercial bank for every DRSP, HD, referral maternity, and RHC that are management centers.*  *The Special Account pays into it quarterly. The amount transferred is determined in relation to the amount of quarterly AAP activities attributable to the CF – HDP, and the performance of the facilities' technical and financial management.* |
| **Procurement** | | | | |
| 1. What procurement system will be used for the GAVI-HSS Program? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners’ procurement procedures) | | | | *The WHO's procurement procedures are used. The Niger's Procurement Code also applies. In the event of conflict, the WHO's procedures take precedence* |
| 1. Do you plan to procure certain items through GAVI's system in-country partners (UNICEF, WHO)? | | | | ***Yes****: Certain acquisitions such as immunizations, contraceptives, medication, cold chain equipment, reagents and medical supplies can be acquired through partners like UNICEF and UNFPA* |
| 1. What is the staffing arrangement of the organization in procurement? | | | | *The entity in charge of procurement has trained personnel. The Common Funds has recruited a procurement expert.* |
| 1. Are there procedures in place for the physical inspection and quality control of goods, works, or services delivered? | | | | *YES: The procedures in place for the physical inspection and quality control of goods, works, or services delivered are those of the CF.* |
| 1. Is there a functioning complaint mechanism? Please describe. | | | | ***YES:*** *Niger's Procurement Code has implemented a mechanism for receiving and managing complaints. The Agence de Régulation des Marchés Publics (The Agency for Procurement Regulation - ARMP) has implemented a committee to regulate disputes (CRD), made up of representatives from the administration as well as the private sector and civil society. All those who file complaints related to procurement can file with this committee.* |
| 1. Are efficient contractual dispute resolution procedures in place? Please describe. | | | | ***YES:*** *There are possible recourses with the Procurement Manager that must be exhausted as a first step. Once the first-pass recourse has been exhausted, the complaint is brought to the CRD.*  *During the execution of public contracts, recourses are reviewed by the Arbitration Committee, an entity created within ARMP for mediation between the parties involved in the public contract. Minutes are drawn up if a consensus is reached. If an agreement is not reached, the parties may resort to the courts.* |
| **Accounting and financial reporting (incl. fixed asset management)** | | | | |
| 1. What personnel is in charge of accounting and financial reporting? | | *Those in charge of accounting are:*   * *At the national level: the Financial and Accounting Division for the DRFM and the head accountant for the Common Funds,* * *At the regional level: 8 Administrative directors and 8 regional CF accountants,*   *For financial reports: In addition to the accounting staff, the following are also involved:*   * *The coordinator, management advisor, comptroller, internal auditor, procurement expert for the Common Funds.* | | |
| 1. What accounting system will be used for the GAVI-HSS Program? (Is there a specific accounting software or a manual accounting system?) | | The OHADA system and TOMPRO software are used for Common Funds accounting. | | |
| 1. How often does the implementing entity produce interim financial reports and to whom are those submitted? | | Financial reports are produced every six months and presented to the Common Funds' partners. | | |
| **Internal control and internal audit** | | | | |
| 1. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures? | YES: The Common Funds has an administrative, financial and accounting manual that describes the internal audit system and the financial management operational procedures. | | | |
| 1. Does an internal audit department exist within recipient organization? If yes, please describe how this department will be involved in GAVI-HSS. | YES. The inspector in charge of finances for the Inspection General is assigned the role of internal auditor. After the financial and accounting audit of the Common Funds for the books closed on 31 December 2011, a request was made to hire an internal auditor who was already involved. One of his GAVI-HSS-related responsibilities will be to ensure that procedures are followed and to verify all supporting documentation before it is validated [sic[ and to carry out internal audits at all national and decentralized facilities. | | | |
| 1. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations? | Common Funds coordination is responsible for implementing the internal audit recommendations | | | |
| External audit of accounts | | | | |
| 1. account audit [sic] or by a government institution (for example, the National Auditing Office/Auditor General)[[3]](#footnote-3) ? | | | YES: The Common Funds procedures plan for the recruitment of an international external auditing firm to audit the accounts  Currently, a private firm has been recruited for the audit of fiscal years 2011, 2012 and 2013 and another firm will be recruited for future PDS activities and for fiscal years 2014 and 2015. | |
| 1. Who is responsible for the implementation of audit recommendations? | | | Each year, the external audit results are reported in the presence of the entire management team from the national, regional and departmental levels. This report is performed by the auditing firm. A plan for implementation of recommendations is developed and monitored by the Common Funds coordination group. | |
| *Question C: Please indicate the main constraints present within the (health sector’s) financial management system. Does the country plan to address these constraints/issues? If so, please describe the Technical Assistance (TA) needs in order to fulfill the above functions.* | | | | |
| *The main constraint within the financial management system remains the extreme mobility of project managers, regarding the ability to capitalize on experience gained with regards to financial management. To meet the challenges of this situation, the common funds has implemented a mechanism by which to improve [staff] competence. In addition, regional accountants are recruited to bring the required support to the different peripheral facilities.* | | | | |

**SUMMARY OF A COMPLETE APPLICATION**

|  |  |  |
| --- | --- | --- |
| **HSS Proposal Forms and Mandatory GAVI attachments**  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | HSS Proposal Form | *X* |
|  | Signature Sheet for Ministry of Health, Ministry of Finance and HSCC members | *X* |
|  | HSS Monitoring & Evaluation Framework | *X* |
|  | Detailed work plan and detailed budget | *X* |

|  |  |  |
| --- | --- | --- |
| **Existing National Documents - Mandatory Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
| 5. | National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions | *X* |
| 6. | National M&E Plan (for the health sector/strategy) | *X* |
| 7. | National immunization plan |  |
| 8. | National cMYP | *X* |
| 9. | Vaccine assessments (EVM, post-introduction assessment, [EPI] reviews), if available | *X* |
| 10. | Health Sector Coordinating Committee Mandate (HSCC) | *X* |

|  |  |  |
| --- | --- | --- |
| **Existing National Documents - Additional Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | Joint Assessment of National Health Strategy (if available) | *X* |
|  | Response to Joint Assessment of National Health Strategy (if available) |  |
|  | If funds transfers are to go directly to a CSO or CSO Network, please provide the 3 most recent years of published financial statements from the  entity, audited by a qualified, independent external auditor. |  |
| … |  |  |

**Applicants are strongly encouraged to carefully read the instructions provided within the relevant sections of the guidelines before completing the application form.**

1. For a definition of ‘systems readiness’ see: <http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/>. [↑](#footnote-ref-1)
2. In special circumstances, GAVI can transfer funds directly to a CSO. Please refer to the application Guidelines for further information. [↑](#footnote-ref-2)
3. **If the annual external audit is to be performed by a private, outside auditor, please include an appropriate audit fee within the detailed budget.** [↑](#footnote-ref-3)