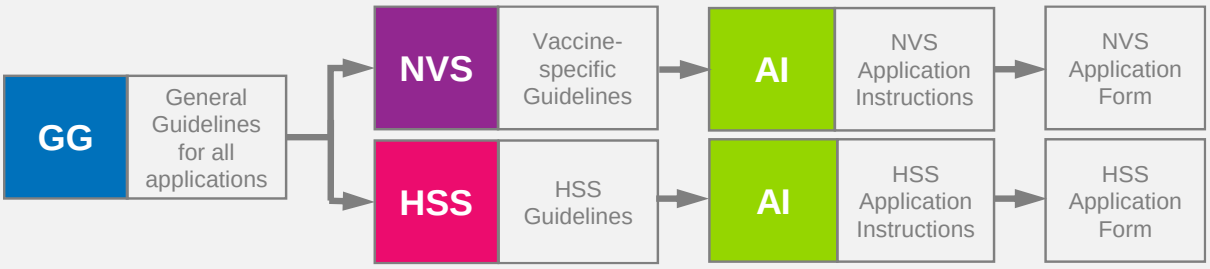
Application Form:
Health System Strengthening Support (HSS) in 2016

Deadlines for submission of application:
15 January 2016
01 May 2016
09 September 2016

Document date: **December 2015**
(This document replaces all previous versions.)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



HSS Application Form

Purpose of this document:

This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.

The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Weblinks and contact information:

All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

CONTENTS

PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	*This should correspond exactly to the budget requested in Question 17 (detailed budget).* ***US$ 23,520,000***	
Does your country have a finalised and approved National Health Sector Plan (NHSP)?	Yes ☒	No ☐
	*Indicate the **end year** of the NHSP: **2027*** ***Provide Mandatory Attachment #8: NHSP (2016-2027 Sectoral Health Strategy)***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes ☒	No ☐
	Indicate the end year of the cMYP **2019** *Provide Mandatory Attachment #11: cMYP*	
Proposed HSS grant start date:	*Indicate the month and year of the planned start date of the grant.* **January 2017**	
Proposed HSS grant end date:	*Indicate the month and year of the planned end date of the grant.* **December 2021**	
Joint appraisal planning:	*Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.* **7 to 18 March 2016 Submission to Gavi's Independent Review Committee**	

2. Application development process *(Maximum 2 pages)*

Provide an overview of the collaborative and participatory application development process.

1- <u>Execution framework of the process</u>

Per memorandum No. D19-232/NS/MINSANTE/SG/DCOOP of the Ministry of Public Health dated 9 September 2015, the process of drafting the application for Health System Strengthening (HSS) support in 2016 was entrusted to a limited team of high-level managers from the Ministry. The Permanent Secretary of the Expanded Programme on Immunisation had been in charge of its technical and administrative coordination. This team has received technical assistance for its overall activity from experts of various backgrounds: WHO, UNICEF, Gavi Alliance, Agence de Médecine Préventive (AMP), World Bank, Clinton Health Access Initiative (CHAI) and civil society.

2- <u>Methodological approach and stages of the process</u>

Starting in October 2015, and after having become thoroughly familiar with the new version of the application form, the team started up preliminary basic desk review on its mission purpose. Its members thereby started up and shared their reflections on:

- The lessons learned from the implementation of the 2014-2015 Gavi HSS reprogramming;
- The recommendations by the Gavi Independent Review Committee regarding Cameroon's HSS proposal

submitted in January 2015;
- The results of the independent assessment of the HSS programme implemented between 2008 and 2015.

This preliminary phase was followed by a meeting held in Yaoundé on 9–13 November 2015 to develop strategic orientation and a rough draft document. Afterwards, an expanded workshop was held in Douala on 1–4 December 2015 to pre-validate the rough draft.

Finally, on 28–30 December 2015, a second meeting of the limited team made it possible to conclude the process, by working out a draft document, which was submitted to the ICC on 8 January 2016 for validation.

3- Key stakeholders

The above-mentioned pre-validation workshop was deeply participative; it brought together a broad and representative panel of organisations and experts with inherent competencies at various levels:

- At the central level: i) the Secretariat of the Sectoral Health Strategy Steering Committee; ii) the Expanded Programme on Immunisation; iii) the Health Sector Investment Support Programme; iv) the Development Cooperation Division; v) the Family Health Department and some sub-departments (Primary Health Care, Immunisation, Health Information Unit, International Partnership Unit, Prevention and Community Action); and vi) the National Technical Unit for Performance-Based Funding (PBF).
- At the intermediate level: the Regional Delegation of Public Health of the Littoral Region and the services in charge of the EPI, Planning and Monitoring & Evaluation.
- At the operational level: The health districts of Nylon and Cité des Palmiers (Littoral Region) and Ngoumou (Centre Region), represented by their Head Physicians.
- At the community level: i) The Technical Secretariat of Regional Funds for Health Promotion, ii) civil society, iii) the Representative of the Mayor of the Douala 2 Commune.

4- Roles of the various stakeholders

At the overall level, three types of contributions were requested and obtained:

- From the limited team: In addition to the desk review and the gathering of the required related documents, this team took charge of the actual writing, the proofreading of the preliminary documents and the final proposal.
- From the community stakeholders: These stakeholders carried out advocacy to provide new dynamics for and better collaboration with the dialogue structures. They proposed solutions to improve community resilience in the implementation of immunisation activities.
- From the partner agencies: The Ministry benefited from guidance from the partner agencies (Gavi, WHO, UNICEF, AMP, CHAI, World Bank), which provided their technical or financial support, each according to what they are authorised to do.
  To facilitate the work in the given time frame, WHO, AMP and Gavi recruited international consultants with experience in preparing such applications for other countries. A Gavi mission provided guidance for Cameroon in the choice of the priority fields of intervention and of the project's overall and specific objectives, as well as for capacity building for stakeholders on Gavi's new performance framework. The other consultants, after having become familiar with the work already completed and the conditions in which the project was going to be developed, put forward recommendations on the content and form of the proposal.

5- Duration of the process and potential difficulties

The process of drafting the final document proposed lasted 10 weeks (from 1 November 2015 to 15 January 2016). Thanks to the expertise of the members of the limited team, to the capitalisation of the lessons learned by the EPI in the strengthening of the health system, and to the multiform support from the technical partners, it can be noted that the process unfolded properly, with no major obstacle. After WHO's pre-review, the feedback from which was shared on 26 January 2016, the amendments were taken into account consensually by Cameroon and its partners, then validated at the ICC meeting of 12 February 2016 in preparation for a new submittal on 15 February 2016.

*Include the following **Mandatory Attachments**:*

#4: *Minutes of ICC meeting, at which the HSS application was endorsed;*

#5: *The minutes of the last three ICC meetings; and*

#15: *ToR of the ICC*

3. Signatures

3a. Government endorsement

*Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment #2**.*

We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.

Minister of Health (or delegated authority)	**Minister of Finance** (or delegated authority)
Name: **Mr André MAMA FOUDA**	Name: **Mr Alamine OUSMANE MEY**
Signature:	Signature:
Date:	Date:

3b. Interagency coordinating committee (ICC) endorsement

*Include ICC official endorsement of the HSS proposal – **Mandatory Attachment #3***

Include signature of each committee member in attendance and date.

Mandatory Attachment #3: **ICC Endorsement of HSS Proposal**

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

Please list all ICC members	**Title / Organisation**	**Name**	**Sign below to confirm:**	
			Attendance at the meeting where the proposal was endorsed	**Endorsement of the minutes of the meeting at which the proposal was discussed**
Chair	Public Health Minister	Mr André MAMA FOUDA		
Vice-chair	Director of Family Health	Dr Robinson MBU		
Secretary	Permanent Secretary of the Expanded Programme on Immunisation	Dr Marie KOBELA		
WHO				
UNICEF				
Other partners				
CSO members				

4. Executive Summary *(Maximum 2 pages)*

Provide an executive summary of the application.

This HSS proposal from Cameroon is focused on immunisation and will give priority to helping remove the following bottlenecks:

- Low level of immunisation coverage for most vaccines;
- Inequitable access to quality immunisation services;
- Weak storage capacity for vaccines;
- Weak capacity in vaccine stock and supply management;
- Absence of a Logistics Management and Information System (LMIS);
- Low level of availability of some vaccines and inputs;
- Low level of coverage of needs in logistics required for the provision of primary health care of remote or marginalised populations;
- The presence of refrigerators that do not meet PIS/PQS standards;
- Poor management of immunisation waste materials;
- Low level of involvement by representatives from the community and CSOs in the process of managing child healthcare, including immunisation;
- Low level of funding for the production of immunisation promotional material and of educational materials;
- Insufficient resources for carrying out community health activities;
- Absence of a strategic document for the development of an information system;
- Fragmentation of the health information management system (low level of inclusion of data from the various programmes), along with a plethora of data collection tools;
- Low level of production of routine data due to the low level of computerisation of the SNIS (National System of Health Information) at all levels;
- Inability to generate reliable information likely to readjust the programme objectives or to guide the appropriate political decisions (2013 EPI external review report);
- Low level of data feedback from the operational to the peripheral level;
- The low managerial capacity of the EPI;
- The low level of EPI coordination of activities at the region and district levels;
- The weak motivation of the personnel, especially at the operational level;
- The vertical nature of the various State programmes and partners in the health sector;
- The weak level of harmonisation/alignment of interventions/service provision at the operational level.

This proposal is perfectly in line with the policy and national strategy documents (2016-2027 Sectoral Health Strategy, 2015-2019 cMYP), keeping in mind that the Sectoral Health Strategy (SHS) is consistent with the Sustainable Development Goals related to mother-child health (SDG 3.1 and 3.2). It also takes into account the recommendations from the Gavi Independent Review Committee on the proposal submitted in January 2015, the observations and suggestions of the WHO pre-review (February 2015) and the conclusions of the 2008-2015 HSS final assessment.

After the bottlenecks were identified, the in-depth analysis of the causes led to determining the objectives of the proposal.

The overall objective of this proposal is to obtain Gavi support that will help to set up a functional and effective health system that will help immunisation activities to be run properly. Specifically, this will involve the following actions between now and 2021:

i) Improving the accessibility of quality immunisation services, especially for the vulnerable populations in 34 health districts, by strengthening the components of the 'Reach Every District/Community' (RED/REC) strategy: planning, strengthening of ties with the community and formative supervision of the outreach and mobile strategies to reach all the targets.

ii) Strengthen the logistical and performance capacities of the EPI supply chain by improving the coverage of the logistics needs in the priority districts.

iii) Strengthen involvement by community stakeholders and CSOs in the promotion of immunisation in 34 health districts. This will be done via the CSOs, whose role will consist in facilitating the establishment of links between the community and the health services, as well as in promoting the communication activities for behavioural change.

iv) Strengthening the Health Information System and data collection at the national level, by improving the availability and quality of health, logistical, administrative and financial data.

v) Improve the management and coordination of the programme, which will make it possible to avoid duplication and to promote complementarity.

In addition to the aforementioned 34 districts, Gavi support will be of a supplementary nature in the 80 HDs already carrying out PBF. This intervention zone was identified consensually with all the stakeholders, based on i) analysis of the situation; ii) identification of the country's immunisation priorities; and iii) the plan to introduce the PBF on a wide scale, which is currently being implemented by Cameroon with technical and financial support from the World Bank, UNICEF and UNFPA. It will concern a total population in 2017 estimated at 10,775,520 including 409,470 children aged 0 to 11 months (47% of the national target). A non-negligible proportion of these people are made up of

remote and marginalised populations: nomadic Mbororo, Pygmies, mountain Kirdis, island inhabitants, refugees and inhabitants of insecure zones.

This proposal covers a five-year period (2017–2021) and is based on the following five objectives:

- **Objective 1:** Between now and 2021, improve the accessibility of quality immunisation services, especially for the vulnerable populations in 34 health districts; US$ 2,724,223 (11.58%).
- **Objective 2:** Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain; US$ 10,347,657 (44%).
- **Objective 3:** Between now and 2021, strengthen involvement by community stakeholders and CSOs in immunisation promotion; US$ 1,861,739 (7.92%).
- **Objective 4:** Between now and 2021, strengthen the Health Information System and data collection at the national level; US$ 2,803,291 (11.92%).
- **Objective 5:** Between now and 2021, improve the management and coordination of the programme; US$ 5,783,088 (24.59%).

The implementation system provides for Cameroon, via its Ministry of Public Health and its Expanded Programme on Immunisation, to be the main responsible authority for this proposal, in legal, technical and institutional terms. However, the technical and financial partners of the Ministry of Public Health, especially the statutory partners of the Gavi Alliance (WHO and UNICEF) as well as the Agence de Médecine Préventive (AMP) and civil society, will join in the implementation operations, each according to what they are authorised to do. The detailed terms of collaboration and partnership within this grant will be written out in a Memorandum of Understanding. The steering and strategic orientation bodies of the HSS proposal will be the Sectoral Health Strategy Steering Committee - SHS-SC (French: *Comité de Pilotage de la Stratégie Sectorielle de Santé - CP/SSS*). This committee will be expanded to the members of the ICC for more effectiveness, better management and good coordination of the interventions. The SHS-SC technical secretariat will also be expanded to the TAG-EPI, for the preparation of the technical applications to submit to the SHS Steering Committee/ICC. A similar system will be set up at the regional and district levels.

The HSS funds will be managed by the TAG-EPI, which will make available to the implementing authorities the funds needed for the implementation of their activities. A marginal share (4%) of the HSS resources will be allocated to the operating costs of the implementing bodies (EPI, civil society, CIS, DCOOP, SHS-SC TS). These costs will essentially include fixed operating expenditures and the allowances for extra and special work by personnel involved in implementation, in accordance with the stipulations of Decision No. 0484 D/MINSANTE/CAB of 9 July 2014, which grants a special bonus for personnel working in the Expanded Programme on Immunisation.

Goods will be acquired through direct purchase, via the procurement and purchase systems of the development partners, in particular WHO for vehicles, motorbikes and computer equipment and UNICEF for the cold chain equipment. The other goods and services will be obtained according to procurement procedures governed by the Bid for Public Tender texts in force in Cameroon.

The monitoring, audit and evaluation of the Gavi HSS grant will take place within the Programme by the experts assigned to do so. The monitoring and evaluation indicators are the standard indicators of the following performance framework: i) immunisation coverage in Penta3; ii) immunisation coverage in MR1; iii) equity in Penta3 geographical coverage; iv) socio-economic equity of immunisation coverages; v) specific dropout rate; iv) and proportion of fully vaccinated children aged 12–23 months. In addition to the above-mentioned indicators, the custom-made indicators are also taken into account (cf. performance framework).

The monitoring and evaluation system of this proposal is that of the Gavi Alliance performance framework; it fits within the national monitoring and evaluation mechanisms of the health sector (National System of Health Information, 2016-2027 Sectoral Health Strategy monitoring and evaluation framework).Coordination meetings involving the various stakeholders will be held monthly, and meetings of the SHS Steering Committee expanded to the ICC will be held quarterly. The periodic reports, validated quarterly at the central level by the SHS Steering Committee, will act as the bases for dissemination of the outcomes of the HSS grant.

At the regional level, the strategic coordination body, which is a subgroup of the SHS Steering Committee, will take care of the monitoring and evaluation of the implementation during the quarterly meetings. The Regional Delegations of Public Health and the Regional Funds for Health Promotion will produce the meeting reports, which will be distributed to the central and operational levels. The implementation of activities will be carried out under the direct supervision of the EPI Regional Units, and half-yearly by the central level. Furthermore, the opportunity of this Gavi funding will make it possible to support the structuring and reinforcement of an integrated and functional HIS.

The financial audits are part of the EPI's monitoring system. Weekly centralisation of the financial operations is planned through the accounting software TOM 2 PRO and a monthly review of financial data at the central level. The internal financial audits (half-yearly) and the annual validation of the financial statements will make it possible to assess ownership of the manual of procedures by the programme managers at all levels, as well as the reliability of the financial management data. The annual external audits will be carried out by an independent firm, to certify that the Gavi HSS grant is used in accordance with the principles of transparency and good governance.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
AEFI	Adverse Event Following Immunisation
AFD	*Agence Française de Développement* (French Development Agency)
AFS	Administrative and Financial Section
AMP	*Agence de Médicine Préventive* (Agency for Preventive Medicine)
BADEA	Arab Bank for Economic Development in Africa
BCG	Bacillus Calmette-Guerin (vaccine)
BICEC	*Banque Internationale pour l'Epargne et le Crédit du Cameroun* (International Bank of Savings and Credit of Cameroon)
BID	*Banque Internationale de Développement* [sic] (International Development Bank)
BUCREP	National Office of Population Census and Research
CAA	*Caisse Autonome d'Amortissement* (Cameroon's public debt redemption fund)
CAPR	*Centre d'Approvisionnement Pharmaceutique Régional* (Regional Pharmaceutical Procurement Centre)
CAR	Central African Republic
CBO	Community-based organisation
CENAME	*Centrale Nationale d'Approvisionnement en Médicaments et Consommables Médicaux Essentiels* (National Procurement Centre for Essential Medicines and Medical Consumables)
CFP	Communication Focal Point
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CMA	*Centre Médical d'Arrondissement* (Arrondissement Medical Centre)
cMYP	Comprehensive Multi-Year Plan
CNS	*Comptes Nationaux de Santé* (National Health Accounts)
COGE	*Comité de Gestion de l'aire de santé* (Health Area Management Committee)
COGEDI	*Comité de Gestion du District de Santé* (Health District Management Committee)
COSA	*Comité de Santé de l'aire de santé* (Health Area Health Committee)
COSADI	*Comité de Santé du District de Santé* (Health District Health Committee)
CSO	Civil Society Organisation
DCOOP	Development Cooperation Division/Ministry of Public Health
DEP	Research and Projects Division/Ministry of Public Health
DEP	Diseases with epidemic potential
DHS-MICS	Multiple Indicator Demographic and Health Survey
DLC	Decentralised Local Communities (*Collectivités Territoriales Décentralisées - CTD*)
DMT	District Management Team
DQS	Data Quality Self-assessment
DROS	Division of Operational Health Research
DTP	Diphtheria-Tetanus-Pertussis
DVD-MT	District Vaccination Data Management Tool
ECAM	*Enquête Camerounaise auprès des Ménages* (Cameroonian Household Survey)
EESI	*Enquête sur l'Emploi et le Secteur Informel* (Survey on Employment and the Informal Sector)
EPI	Expanded Programme on Immunisation
EVMA	Effective Vaccine Management assessment
FRPS	*Fonds Régionaux pour la Promotion de la Santé* (Regional Fund for Health Promotion)
GDP	Gross Domestic Product
GIP	*Groupement d'Intérêt Public* (Public Interest Group)
GPHC	General Population and Housing Census
HCR	Office of the UN High Commissioner for Refugees
HA	Health Area
HD	Health District
HF	Health facility
HIS	Health Information System
HIU	*Cellule des Informations Sanitaires* (Health Information Units)
HKI	Hellen Keller International
HMN	Health Metrics Network
HPV	Human Papilloma Virus
HRD	Human Resources Department/Ministry of Public Health
HRH	Human Resources in Health
HSCC	Health Sector Coordination Committee
ICC	Inter-Agency Co-ordination Committee
ICS	Immunisation Coverage Survey
IHC	Integrated Health Centre
IMCD	Integrated Management of Childhood Diseases
IPV	Inactivated polio vaccine
JANS	Joint Assessment of National Health Strategies

JRF	Joint Report Form (WHO/UNICEF)
KAP	Knowledge, Attitudes and Practices (survey)
LA	Local associations
LANACOME	*Laboratoire National de contrôle de Médicaments et produits pharmaceutiques* (National Laboratory of Medicine and Pharmaceutical Product Supervision)
LLIN	Long-lasting insecticidal nets
MAR	Monthly Activity Report
MCV	Measles vaccine
MDA	*Médecins d'Afrique* (Doctors of Africa)
MDG	Millennium Development Goals
MenAfriVac	Meningitis A vaccine
MINEPAT	Ministry of the Economy, Planning, and Territorial Development
MOH	Ministry of Public Health
MSF	*Médecins Sans Frontières*/Doctors Without Borders
NGO	Non-Governmental Organisation
NHMIS	National Health Management and Information System
NHSP	National Health Sector Plan
NIS	National Institute of Statistics
NITAG	National Immunisation Technical Advisory Group
NPP	National Pharmaceutical Policies
ONSP	*Observatoire National de Santé Publique* (National Observatory of Public Health)
OPV	Oral Polio Vaccine
PAISS	*Projet d'Appui aux investissements dans le Secteur de la Santé* (Support Programme for Health Sector Investments)
PCV13	13-valent pneumococcal conjugate vaccine
PETS	Public Expenditure Tracking Survey
PIS	'PIS' catalogue listing specifications for EPI supplies and equipment
PISE	*Plan Intégré de Suivi Evaluation* (Integrated Plan for Monitoring & Evaluation)
Plan	The international NGO "Plan"
PNC	Pre-natal consultation
PNLMMI	*Programme National de Lutte contre la Mortalité Maternelle et Infantile* (National Programme to Combat Maternal and Infant Mortality)
PROVARESSC	*Plateforme pour la Promotion de la Vaccination et le Renforcement du Système de Santé au Cameroun* (Platform for the Promotion of Immunisation and Health System Strengthening in Cameroon)
PRP	Problem Resolution Plan
RBF	Results-Based Financing
RDPH	Regional Delegation of Public Health (*Délégation Régionale de la Santé Publique*)
RED	Reach Every District (Approach)
SDGE	Strategic Document for Growth and Employment
SHS	Sectoral Health Strategy (*Stratégie Sectorielle de la Santé - SSS*)
SHS-SC	Sectoral Health Strategy Implementation Steering and Monitoring Committee (*Comité de Pilotage et de suivi de la mise en œuvre de la Stratégie Sectorielle de la Santé*)
SHS-SC TS	Technical Secretariat of the Steering Committee of the Sectoral Health Strategy
SMT	Stock Management Tool
SNIS	*Système National d'Informations Sanitaires* (National System of Health Information)
SYNAME	*Système National d'Approvisionnement en Médicaments Essentiels* (National Procurement System for Essential Medicines)
TAG-EPI	Technical Advisory Group of the Expanded Programme on Immunisation
TFP	Technical and Financial Partners
TT	Tetanus Vaccine (Tetanus Toxoid)
UNFPA	United Nations Population Fund
WUENIC	WHO/UNICEF Estimates of National Immunisation Coverage

PART B: BACKGROUND

6. Description of the National Health Sector *(Maximum 1 page)*

*Provide Attachment #**8:** NHSP or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

This description is based on the pillars of the health system.

1- Services and care offer:

In Cameroon, the health system is organised into three levels: the central level, the intermediate level (10 Regional Health Delegations) and the peripheral level (189 health districts, 1766 health areas). The new Sectoral Health Strategy (SHS) provides for the setting up of a fourth level, called the *community level.* The health facilities that provide healthcare services are categorised from Category 1 to Category 7. There were 4034 of these in Cameroon in 2014, of which 56% were in the public sub-sector (public administration) and 44% in the private sub-sector (profit or not-for-profit). In accordance with the MOH partnership strategy guidelines, the State regularly provides grants to the networks of private not-for-profit health facilities and the NGOs.

It should be noted that 80.6% of the population lives less than 5 km from a health facility (IHC, CMA, District Hospital). But there are disparities in rural areas (69.6%) and in the Adamawa (54.2%), Far North (65.7%) and East (67.7%) Regions. (Source: 2007 NIS Report) The infrastructures and technical platforms of some health facilities are poorly operational and additionally suffer from a lack of quality approach. To date, no survey has been made in the area of hospital waste management in Cameroon. Furthermore, certain vertical health programmes such as the EPI aside, the availability of services and the operational capacities of the health facilities are not very well known. With regard to use of services, the available data show a PNC1 coverage rate of 82.8% and an immunisation coverage rate (ICR) of 93% (Penta1), with 29% of health districts having a Penta3 ICR less than 80%.

2- Human Resources in Health:

The 2013–2017 Human Resources Development Plan (HRDP) indicates that the number of healthcare personnel (doctors, nurses and midwives) per 1000 inhabitants was 1.07 in 2010. From among these personnel, nearly 2/3 (66%) work in the public sub-sector, compared to 20% in the private/religious sub-sector. There are great disparities in the geographical distribution of HRH, as they are much more concentrated in the larger cities. The number of healthcare personnel entering the job market annually is approximately 500 doctors, 2000 state-registered nurses, 250 midwives and 100 nurse assistants specialising in community health. This number is greatly superior to the absorption capacity of the pubic sub-sector. While efforts have been made to improve the quality of the initial training of doctors and midwives (audits, harmonisation of curricula, etc.), this has not been the case for nurses training. The number of community liaisons was 367 in 2011. Their status is not clearly defined, and they work essentially within the framework of implementing certain vertical health programmes. The human resources in health (HRH) management is strongly centralised in the public sub-sector, with weak coordination between the public administrations and the private sub-sectors (profit and non-for-profit). HRH retention is a problem; their attrition rate is 1000 persons per year in the public sub-sector. The systems for management of the careers and for the evaluation/motivation of personnel are poorly operational, thereby reducing the motivation of personnel. However, initiatives such as widespread introduction of results-based funding and increased HRH loyalty in the so-called difficult positions are possible solutions.

3- Procurement & supply chain management system

In 2013, Cameroon adopted a National Pharmaceutical Policy. Its major challenge is to improve the geographical accessibility, affordability and correct usage of quality essential medicines. There is a National Agency for Pharmaceutical Regulation (ARNP). However, this organisation functions poorly (2016-2027 SHS). The organisation of SYNAME (National Procurement System for Essential Medicines) is based, at the central level, on the CENAME (National Procurement Centre for Essential Medicines and Medical Consumables), the for-profit wholesale distributors and the private not-for-profit procurement centres. At the devolved level, there are the Regional Fund for Health Promotion (FRPS) and the pharmacies of public and private health facilities. Quality control is not systematic for the imported medicines, and only a small proportion of circulating batches is tested in post-marketing. Counterfeiting has developed, and there is a huge network of illicit procurement that fuels the street market in medicines and that may have connections with the licit sector (2016-2027 SHS).

In the field of vaccine management, the memorandum on the agreement on procurement services signed on 18 August 2009 stipulates that the Ministry of Public Health shall use the UNICEF channel to purchase the supplies, equipment and other materials intended to support the EPI activities. The new and underused vaccines (yellow fever, DTP3-HepB-Hib, PCV13, rotavirus vaccines) are co-financed with Gavi. The traditional vaccines (BCG, OPV, TT and MR) are funded by the Government. The 2013 Effective Vaccine Management Assessment (EVMA) recommended drafting and implementing a preventive maintenance plan for the cold chain equipment, vehicles and buildings. The total cost of this plan for the supply chain equipment is US$ 1,423,467 for the 2014-2018 period. In 2014, the Gavi Alliance granted US$ 900,000 for the funding of the supply chain through UNICEF. This funding enabled the purchase of three cold rooms with positive capacity of 70m^3 and negative capacity of 20m^3 at the central level, and of positive capacity of 30m^3 for the Northwest Region. The installation and rehabilitation of this equipment improved the positive storage capacity at the central level by 100m^3. As the introduction of new vaccines continues, the need in positive storage space is being felt. This

need is estimated to be 280m^3, representing seven cold rooms of 40m^3 for the central and regional storage facility (EPI forecast, UNICEF 2015). The purchase of these seven cold rooms will cover the needs up to 2021 and will make it possible to replace the two former cold rooms from the central storage facilities, as well as the two other 40m^3 ones obtained in 2011 that are not approved.

At the operational level, between now and 2019, 1286 pieces of cold chain equipment will be over 10 years old. Of this equipment, 229 items are out of order due to breakdown (212 refrigerators and 17 freezers). Cameroon proposes to purchase 900 solar refrigerators between 2017 and 2021. Support from the cold chain equipment optimisation platform will enable purchase of the other 900. This will make it possible to cover all the needs of the health facilities between now and 2021. Cameroon will build a large warehouse at the central level with Gavi support. The Ministry of State Properties has given a site for this purpose. The management of inventories is carried out at the central and regional levels thanks to the Stock Management Tools (SMT) perfected by WHO and in manual registers. The health districts use the District Vaccine Data Management Tools (DVD-MT) and the health areas the registries of vaccine movements. Order forms and manual registers are used at all levels. The vaccine supply schedule at the central level is half-yearly, with a reserve stock of three months. Quarterly supply of the southern regions is carried out by the TAG-EPI cargo van, whilst the northern regions are supplied via private transport companies. The health districts and areas are supplied on a monthly basis. Vaccines and injection supplies are transported to the regions by road and by major route. Since 2012, the EPI has had a large van that delivers to the seven southern regions. A refrigerated cargo van purchased with Elma funds has just been received by the MOH. Current coverage of health district needs in vehicles for formative supervision is 60% (105 vehicles). Seventy-three of these vehicles (70%) will be replaced in five years. In order to deal with the recurrent problem of waste management, plans have made to make the 40 gas incinerators purchased from C2D funds operational and to obtain 40 others between now and 2021.

4- Health information systems:

Unfortunately, the 2009-2015 Strategic Plan for Health Information System Strengthening has not been evaluated. The data collection is carried out within the health facilities (HF) with the help of registries. These latter are not always harmonised, and the periodic summaries that are sent are made with printed copy forms. The summarising and sending of data are carried out within the coordinating bodies (districts, regions and central level), with the help of summary sheets and input and analysis software. The DHIS2 (District Health Information Software 2) is currently being developed at the MOH, as is the mapping of the health service offer, with the help of the geographical information system (GIS). This information should make it possible to improve the availability of quality health information.

With regard to integrated disease surveillance and response, the speed in sending data has been improved thanks to increased use of information and communications technology ('zero-cost' telephones, Internet). However, efforts still remain to be made in the following areas: coordination, alert system and management of confirmed epidemic system.

Certain programmes such as the EPI ensure the control and quality of data via: monthly meetings to validate the data, periodic audits of data quality, formative supervisions accompanied by administration of the DQS, and decentralised integrated monitoring. The Immunisation Coverage Survey (ICS) is carried out every three years and is very often accompanied by a larger-scale survey (MICS, DHS-MICS, EPI external review). Furthermore, each year the EPI produces several types of programmatic reports (EPI annual activities report, annual progress report to Gavi, JRF or joint WHO/UNICEF/Country).

5- Funding:

Cameroon does not have a national strategic plan for healthcare funding. There is therefore no national logical framework corresponding to the various functions of funding (collection of resources, risk-sharing mechanisms, purchase of health services). However, many programmes and projects have developed funding strategies. This is especially the case of the cMYP (comprehensive multi-year plan) of the EPI and the HIV/AIDS funding strategy. It should be noted that, according to the 2011 National Health Accounts, the total volume of healthcare funding was FCFA 504 billion, or 4% of GDP. The main sources of funding are: households (52%), the Government (33%), the donors (14%) and the private sector (1%).

6- Legal and governance environments

Law No. 96/03 of 1996, a framework law in the field of healthcare in Cameroon, is a health policy document that clearly advocates access to health services including immunisation for all people of Cameroon. This is also taken up in '2035 Cameroon Outlook' (*Vision Cameroun 2035*) in the Strategy Document for Growth and Employment (SDGE) and in the 2016-2027 Sectoral Health Strategy Despite the existence of a health sector Steering Committee, the health sector remains characterised by a plethora and diversity of other coordinatiing bodies. Indeed, most of the health programmes and projects have an inter-sectorial or inter-ministerial steering body (National Coordinating Body for Funding by the Global Fund to fight AIDS, Tuberculosis and Malaria [French: *Instance de Coordination Nationale pour les financements du Fonds Mondial de lutte contre la TB, le VIH et le Paludisme*], ICC, PLMI, etc.). These coordinating bodies of vertical programmes often have no direct link with the SHS Steering Committee. This fragmentation of coordination and strategic steering is also reflected at the regional level and hinders the effectiveness and above all efficiency of interventions in the sector. With total health expenditures at US$ 63 per person per year in 2012, Cameroon saw results equivalent to countries that spend three times less. One of the reasons for this may be the absence of an overall strategy for healthcare financing in Cameroon. These dysfunctions were taken into account in the 2016-2027 SHS.

As for regulation in the sector, the audit and control actions are limited by the insufficiency in logistical and financial means, as well as by the fact that the recommendations stemming from inspection missions at all levels are not

implemented. Social control of health interventions, which is one of the ways the community participates in health system activities, remains ‘quite weak’. Dialogue structures exist at all levels of the health pyramid, but they do not work well for the most part.

*Provide Attachment #**8:** NHSP or equivalent and reference which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

7. National Health Sector Plan (NHSP) and relationship with cMYP (*Maximum 2 pages*)

Describe the relationship of the cMYP to the national health strategy.

*Provide: **Mandatory Attachment #8**: NHSP and #11: cMYP; and if available: Attachment #18: Joint Assessment of National Health Strategy (JANS); and Attachment #19: Response to JANS.*

The 2016-2027 Sectoral Health Strategy is the reference framework document for the implementation of healthcare programmes and projects. It has just been validated by the Health Sector Coordinating Committee (HSCC). It includes five strategic aspects: health promotion, disease prevention, curative treatment of cases, health system strengthening and strategic governance/steering. This SHS will be implemented via several National Health Sector Plans (NHSP) that correspond to the planning cycles, the first of which covers the 2016-2020 period (NHSP 1). Development of the NHSP 1 is currently underway.

One of the priority objectives regarding service provision in this SHS is to 'reduce the risk of occurrence of potentially epidemic diseases and major public health events in at least 90% of health districts between now and 2027'. To do so, four strategies will be implemented, three of which are directly related to the objectives of the strategic plan for immunisation (2015-2019 cMYP). These are: i) strengthening of the disease surveillance system; ii) improving prevention of vaccine-preventable diseases; and iii) strengthening preparation for and response to epidemics.

The cMYP objectives concerning health system strengthening in relation to the EPI can be found in the two cross-cutting strategic or support aspects of the SHS and the NHSP, i.e. health system strengthening and governance/strategic steering.

It should be noted that the processes for developing the 2016-2027 SHS and the 2015-2019 cMYP have both been strongly participative. The various editorial teams have worked together to produce these documents. The fact that the 2016-2019 cMYP came before the 2016-2027 SHS and the 2016-2020 NHSP made it possible to create coherency among the progress reports, objectives, interventions and indicators adopted in the 2016-2020 NHSP and the 2015 [sic]-2019 cMYP. Similarly, the costing of the SHS and NHSP, which was estimated with the help of the OneHealth Tool, has taken into account the cMYP budget.

The 2016-2027 SHS was validated on 5 January 2016 and for this reason cannot be subject to external evaluation by the JANS (Joint Assessment of National Health Strategies) method. However, before it was developed, an internal evaluation of the previous strategy (2001-2015 SHS) was carried out. This evaluation did not take into account the EPI or the vertical health programmes specifically. After this analysis, the bottlenecks found were categorised according to UNICEF's so-called 10 determinants approach:

- *Legislation, regulation and policy*: Weak political commitment to the implementation of the Health SWAp (since 2011, AFD and GIZ/KfW have been the only two TFPs using this approach) and to public financing of healthcare (which remains around 8%). Along the same lines, it was found that the financial productivity of the health facilities is not sufficiently monitored so as to further optimal use of public financing. The health system does not yet ensure protection against the risk of disease for the entire population: only 2% are covered by mechanisms related to the health system. Direct payments, which represent nearly 95% of private healthcare expenditures, remain the main way of obtaining healthcare. Furthermore, due to the absence of a public health code and to legal voids that have been observed, it has not been possible to provide better supervision for the stakeholders in the health sector.

- *Budget/expenditures*: The system remains marked by the existence of multiple systems for financing healthcare (28 counted in 2013). This shows the absence of an integrated approach and a weak level of coordination in the management of financing on the one hand, and insufficient leadership on the other. There has been little information on financing deployed in the sector (private funding received by the health facilities; funding of certain related sectors that are providers of preventive, curative and promotional healthcare and services, as well as of those of decentralised local communities). For this reason, it has not been possible to avoid duplication of resources and to act coherently and efficiently to meet the most crucial needs (horizontal equity). Furthermore, lack of understanding of the implementation procedures in the MoU by the implementing authorities leads to chronic delays in fund disbursements and in the carrying out of planned interventions.

- *SHS management (planning, coordination, monitoring & evaluation)*: The objectives put forward and the interventions chosen did not always match the institutional capacities and the previous paces of progress. The mechanisms of accountability of those who implement the SHS are neither described nor mentioned in the SHS. Some partner administrations that provide curative, preventive and promotional care have not been identified and been formally made responsible within the framework of SHS implementation. Furthermore, the 2007-2015 SHS has not brought to light the needs in technical assistance. The responsibilities and the aspects of accountability of the stakeholders at the decentralised level have not been clarified enough, and this is a source of conflict in scope of activities and of ineffectiveness.

The TS of the SHS-SC has not fulfilled its role of giving impetus and dynamics to the sector, and this has limited the overall performance of the latter. The absence of objectives and targets at the regional level has prevented allocation of

resources according to needs. Some tools such as the SQI had been planned for evaluation of performances of the districts and health facilities. However, the data generated by these tools have not been sufficiently utilised. The source values and target values of the SHS monitoring indicators have not been recorded, thereby making it difficult to monitor the sector's performance. In addition, they were very great in number. The absence of a risk management plan meant that it was not possible to foresee the structural and economic obstacles to achieving strategy outcomes. This reinforced an attitude that was more reactive than proactive among the stakeholders implementing the SHS.

Availability of essential consumables and inputs: The absence of an infrastructure development plan in the SHS suggests that development of infrastructures has not respected the requirements of the health map. The 2001-2015 SHS does not mention the aspects of personnel motivation. Yet, health system strengthening is the pillar of performances in the sector.

Affordability: The ineffectiveness of strategies seeking to ensure universal healthcare coverage (especially in funding) has been a major obstacle in meeting equity objectives.

Social and cultural practices and beliefs: Corruption in public services is a burden that makes access to healthcare difficult, especially for the poorest strata.

Main actions for monitoring the recommendations of the 2016-2027 SHS internal evaluation:

- **Healthcare funding:**
  - Widespread shift to Results-based Financing (RBF);
  - Development of universal healthcare.
- **Management of medicines, reagents, consumables and medical devices:**
  - Empowerment of the national authority on pharmaceutical regulation.
- **Human resources:**
  - Establishment of mechanisms to match positions and profiles in the administrative bodies;
  - Gradual decentralisation of human resources management.
- **Providing health services:**
  - Developing a national system for service quality assurance;
  - Creation of a fourth level of healthcare called ‘community level’.
- **Governance and strategic management**:
  - Creation of regional strategic steering committees.

8. Monitoring and Evaluation Plan for the National Health Sector Plan *(Maximum 2 pages)*

Provide background information on the country M&E arrangements.

The weakness of the national M&E system was a real obstacle to the implementation of the 2001-2015 SHS. In fact, there is no formal monitoring and evaluation plan for the latter (2011-2015 NHSP). However, monitoring and evaluation activities are carried out at all levels of the health pyramid. At the health area level, data are collected routinely. A monthly summary is made and sent to the chain of command (district, regional health delegation, monitoring unit at the central level). This monitoring especially concerns the data on immunisation; prevention of HIV transmission from mother to child (PMTCT); treatment for persons living with HIV (PLHIV); tuberculosis; maternal mortality; diseases with epidemic potential (DEP); and vaccine-preventable diseases. These data are discussed, and corrective actions are taken during institutionalised coordination meetings at all levels. A Multiple Indicator Cluster Survey (MICS) was carried out in 2014, and the results have already been presented.

In order to correct this deficiency, monitoring and evaluation will be one of the main priorities of the 2016-2027 SHS and the various ensuing NHSPs.

1- <u>Monitoring and Evaluation Framework</u>:

The 2016-2027 SHS provides for the institutional and operational capacity building of the Steering and Monitoring Committee for Implementation of the Sectoral Health Strategy. Theme-based technical groups will be created to back up the Technical Secretariat of the sector's Steering Committee. A coordination and strategic management body will also be created at the regional level. This regional committee will be chaired by the Governor and will bring together the Regional Delegates of the MOH and of partner administrations, the Prefects, the Government Delegates to urban communities, the representatives of the technical and financial partners and civil society. The Committee secretariat will be jointly manned by the Regional Delegate for Public Health and the Administrator of the Regional Fund for Health Promotion. It will be expanded to the various existing health-related committees in the region (HIV/AIDS, maternal and child mortality, etc.). It will act as a framework for coordination, strategic monitoring and guidance for the technical monitoring committees that exist in the health and related sectors.

At the health district level, the institutional and operational capacities of the management teams will also be strengthened, to allow them to fulfil their roles more effectively.

2-<u>Organisation of the 2016-2027 SHS monitoring</u>

Reviews (annual, mid-term and/or end-of-cycle) will be organised to act as an inclusive and continuous critical reflection framework, so as to see to the effectiveness and implementation of the SHS. These reviews will be developed in a participative manner with the development partners and will mainly be led by the theme-based groups established for this purpose. The outcomes of these theme-based groups will be consolidated by the Technical Secretariat of the sector's Steering Committee.

The routine and epidemiological surveillance data collected by the National System of Health Information (SNIS) will ensure the monitoring of the system at each level of the system. Service Availability and Readiness Assessment (SARA) type evaluations and epidemiological or social surveys will also be carried out to monitor the progress made.

The supervision and monitoring system will be strengthened at all levels. Each level of the health pyramid will in fact develop a regular plan for monitoring health activities. Supervision of the implementation of these plans will be carried out in cascade fashion, as follows: The central level will supervise the regional level, which in turn will take care of supervising the District Management Teams (DMTs). The directors of the health areas will be supervised by the DMTs, whereas the community health workers will be supervised by the directors of the health areas.

3- <u>Organisation of the 2016-2027 SHS evaluations</u>

The SHS mid-term and final evaluations will be carried out internally and externally.

The internal evaluations will be carried out based on the plan implementation reports at all levels of the health pyramid (central, regional and district levels), periodic supervision reports on each level, audit reports of health-related activities as well as financial and accounting reports. The control and inspection reports will also be taken into account in the evaluation.

The external evaluations will be initiated by the Ministry of Public Health and the Ministry of the Economy,

Planning and National Development, with the support of the TFPs. They will be validated by the SHS Steering Committee. The external evaluation will assess both the level of attainment of the intermediate objectives and the administrative, financial and technical aspects of the implementation of the plans. The final evaluation will fall within the process of planning health action for the future periods. It will assess the level at which the SHS objectives have been met, as well as the impact of the implementation plans at the end of the execution period, and it will draw lessons from the results. This evaluation will be carried out for all the SHS objectives, including those related to immunisation.

4- 2016-2027 SHS M&E indicators

The indicators adopted for outcome-based monitoring and evaluation will be divided into two major groups:

(i) the monitoring indicators that include input, activity and output indicators;

(ii) the evaluation indicators that are effect and impact indicators. They will make it possible to measure the level to which the set objectives have been met. They will be developed and adopted consensually along with the various stakeholders before the start of the NHSP implementation.

A monitoring-evaluation and strategy-review plan will be worked out, as will the institutional framework and the M&E tools according to the IHP+ approach.

*Provide **Mandatory Attachment #9**: National M&E Plan (for the health sector/strategy), as well as any sub-national plans, as relevant. If this does not exist, explain how the National Health Sector Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment #16**: Data quality assessment report; and **Attachment #17**: Data quality improvement plan.*

***Pooled fund** applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

9. Alignment with existing results-based financing (RBF) programmes (where relevant) *(Maximum 1 page)*

Indicate whether your country will align HSS support with existing results-based financing (RBF) programmes.

*If yes, provide **Attachment #30**: Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.*

Together with the World Bank and the other partners involved in immunisation in the country (WHO, UNICEF, CHAI, CDC, AMP), Cameroon has decided that part of the Gavi HSS grant will be allocated to the national PBF programme, which is supported by the World Bank, in order to improve it – especially its immunisation aspect.

The PBF approach will be used as a performance-incentive tool to implement Activity 5.7 of Cameroon's Gavi HSS proposal, i.e. 'Improve the performance of the immunisation teams at the operational level'. This approach will be consistent with the World Bank project (Health Sector Support Investment Project [FR: PAISS]), which seeks to improve the use and quality of mother-child health services via performance based funding (PBF) at the various levels of the health system, including the community level. The Gavi HSS support for PBF focused on immunisation is thus a supplementary action of Component 1 of the World Bank project, which conditions the payment of PBF allowances to service providers to the quantity and quality of the services provided by the health facilities at all levels of the health pyramid and to Community Health Workers working under contract.

Concretely, the Gavi support to strengthen the PBF national programme supported by the World Bank will consist in:

- Improving the remuneration system for quantitative indicators related to immunisation. In addition to the immunisation indicators already remunerated by the State and the other partners, Gavi will finance the remuneration of Penta3 coverage and MCV coverage in terms of PBF allowances in all the HDs that are already implementing this strategy to improve the universal coverage of high-impact interventions (80 HDs).
- In addition to the remuneration of the new indicators, the Gavi support will make it possible to introduce new qualitative indicators for immunisation services into the country's PBF model without additional cost.

This action seeks to boost immunisation services or make them attractive again in the health facilities, especially in the regions where the security situation is constantly deteriorating, making the working conditions of the healthcare providers more difficult and demotivating.

Indeed, a more substantial financial incentive for the immunisation indicators will be more attractive and will help bolster the motivation of the healthcare personnel and workers. The healthcare providers will tend to organise and increase the number of appropriate strategies for reaching the vulnerable and remote populations, and to improve overall immunisation quality. Eventually, this action will have to enable a decrease in the number of children who are unvaccinated or partially vaccinated, and consequently a significant improvement in immunisation coverage and in equity.

The institutional framework of the immunisation-focused PBF is that of the national PBF model. It is built on the principle of the separation of duties among the main stakeholders of the healthcare system. Thus, through its support for HSS, Gavi will essentially play the role of immunisation service purchasers via the PBF World Bank (PAISS) project after the signing of an MoU. This latter will give more details on the terms of implementation, all the while specifying i) the indicators to purchase (Penta3 and MCV), ii) the monitoring tools of the immunisation-focused PBF component and iii) the amount of management costs related to the supplementary work generated at the project's management unit level. To carry this out, the PAISS Management Unit (FR: *UGP*) will – as is done for the UNFPA and UNICEF support for strengthening national PBF – open a bank account into which the advance funds from Gavi will be sent, in order to ensure the monthly payment of the immunisation allowances at the health facilities.

The Gavi HSS grant will not cover the costs of the institutional reinforcement component of Cameroon's PBF supported by the World Bank, especially in the fields of stakeholder training, the management and monitoring of PBF contracts of all levels of the health system and the setting up of a unified PBF data management and information system. This is because the PBF aspect of the present proposal will be included in the institutional framework of the PBF already established in Cameroon. Furthermore, the implementation procedures as well as the entire management system already set up and described in the national guidebook of PBF implementation will be used for the execution of immunisation-oriented PBF. Therefore, there will be no additional start-up costs. However, management costs (3 to 5% of the PBF budget) will be transferred to the PAISS, which is the main implementing agency of the PBF component of the Gavi HSS support.

The results framework and the budget concerning the PBF aspect of the proposal are presented in the concept note (***Attachment No. 30***).

PART C: APPLICATION DETAILS

10. Health System Bottlenecks to Achieving Immunisation Outcomes (*Maximum 3 pages*)

Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach Optional Attachment 33: Health system bottleneck analysis.

The work that led to identifying and analysing the below bottlenecks are based on desk review of the following documents:

- the 2015-2019 cMYP;
- the 2013 EPI External Review;
- the Effective Vaccine Management assessment (2013 EVM);
- the 2013 EPI national inventory of equipment;
- post-introduction evaluation of PCV13;
- the reports by the regional workshops of the 2013 EPI and the reports by the ICC meetings on the decrease in EPI performances;
- the independent assessment of the response to the polio epidemic in Cameroon;
- the 2014-2020 strategic communications plan;
- the September 2015 report on the evaluation of Gavi Alliance support for 2008-2015 Health System Strengthening;
- the World Bank Report on Health and the Healthcare System (2013 *RaSS*);
- the 2016-2027 Sectoral Health Strategy.

The main problems of the healthcare system that are limiting immunisation-related outcomes are summed up by Gavi activity area and by level of healthcare system, as follows:

1- <u>Provision of services</u>

<u>At the national level</u>:

The inequitable access to quality immunisation services leads to weak coverage of the latter for certain population groups because of their geographic location (remote or insecure zones) or their beliefs. The massive influx of refugees in recent years in the northern and East regions due to conflicts in northern Nigeria and in the CAR are putting extra pressure on the health system. This is characterised by a low proportion of districts with Penta3 > 80% coverage (only 70% of HDs in 2014). There are also economic gaps (according to the PETS 2, 60% of the population is not able to deal with healthcare expenditures). The rate of full immunisation coverage is 32.3% in the quintile of poorest families, compared to 70.3% in the richest quintile (2011 DHS-MICS). However, there is no gender-specific problem in the access or usage of immunisation services (2011 DHS-MICS).

The five groups of populations or communities affected by the inequalities of immunisation access and coverage and the main obstacles to immunisation are as follows:

-*The Mbororo communities* made up of nomadic herdsmen spread out all over the country, with strong concentrations in the northern regions. They are estimated to number more than 60,000. They live in certain parts of the Adamawa, East, Northwest and Far North regions, and along the borders with Nigeria, Chad and the Central African Republic. They generally live away from cities and far from sedentary peoples; this complicates their access to basic healthcare services.

The Pygmy communities (the Bakas, Bagyelis and Bedzan), which are characterised by a lifestyle marked by conservation of their ancestral traditions and their attachment to the forest, from which they obtain all their food and pharmacopoeia. Long distances separate their camps and health facilities, thereby acting as a barrier to their access to healthcare services. They live in the East and South regions.

- *The 'Kirdi' communities or mountain peoples,* who live in the Mandara Mountains in the Far North Region, specifically in the Tokombéré, Mora and Kolofata health districts. Their exact number is not known.

- *The island communities*. They live on the islands along the seacoast of the Littoral Regions: Djéballé (1000 inhabitants), Manoka (20,000 inhabitants) and Cap Cameroon (3000 inhabitants); the peninsulas of Bakassi, Erong and Akwabana in the Southwest Region at the border between Cameroon and Nigeria; and the islands along the banks of Lake Chad: Darak in the Mada health district in the Far North Region.

- *Populations in zones of insecurity*. Ten health districts in the Far North Region are concerned (Kousseri, Goulfey, Mada, Makary, Mora, Kolofata, Koza, Mokolo, Mogodé and Bourha). In the East Region, the health districts bordering the Central African Republic (CAR) are the most concerned (Garoua Boulaï, Kette, Ndelele, Batouri, Yokadouma and Moloundou).

<u>At the region and district level:</u>

➢ Lack of quality immunisation services, which is itself due to the weak level of implementation of the

immunisation strategies (2015-2019 cMYP), especially insufficiency in strategies to reach remote populations and certain populations of disadvantaged social classes in urban and rural areas and in the implementation of intensified immunisation activities. The number of non-vaccinated children between January and August 2015 was 134,204, out of an estimated target of approximately 832,000 (EPI administrative data). Here we can note a weak level of implementation of the 'Reach Every District' approach (2013 EPI External Review report). Less than 50% of health facilities immunise on a daily basis or offer outreach strategy immunisation services. There has hardly been any supervision of healthcare personnel of the operational level (health districts and areas), and likewise hardly any meetings to coordinate and/or review the immunisation data in the entire country. There are many causes for this, most of a systemic nature: i) insufficient number of healthcare personnel, especially in the rural districts and some isolated regions such as the Southwest and Far North Regions; ii) the low level of accountability of available personnel in the health facilities; iii) insufficient coverage in terms of vehicles; iv) the near absence of cold chain equipment powered by renewable energy (e.g. solar refrigerators); v) the absence of corrective maintenance of cold chain equipment already available in the health facilities; vi) the fact that dialogue structures work poorly and the weak level of involvement by local stakeholders (elected officials, opinion leaders, decentralised community authorities, CBOs and CSOs) in the promotion and strengthening of the local immunisation system.

- The absence of continuity in immunisation services, with an overall drop-out rate higher than 15% (2015-2019 cMYP) and the principal cause of which is the weak level of implementation of the 2014-2020 EPI strategic communication plan activities at all levels. Indeed, we can note a low level of execution of activities to help generate demand and communication for behavioural change; this can be partially explained by insufficient involvement by the community. While communication and awareness-raising are effective on the occasion of SIAs (in particular the polio NIDs and LIDs), they remain insufficient for routine immunisation activities. Besides the geographical barriers such as difficulty of access and the public's distance from health facilities offering immunisation, other factors such as the low level of satisfaction among beneficiaries, ignorance or negligence among some parents, and mistaken perceptions about the vaccine itself can be mentioned. With regard to the five vulnerable groups mentioned above, demand for immunisation services is low for reasons having to do with religion, culture, poverty level, lifestyle (movements of nomadic peoples) and having settled in remote areas.

At the community level:

- The system for looking for children lost from immunisation follow-up has not been developed, nor has the system for coverage of problem populations. The reasons put forward to justify this deficiency are particularly lack of funding, lack of transportation and lack of fuel (2014-2020 Strategic Communication Plan, EPI).
- The insufficiency in implementation of communication activities for routine immunisation and more generally the insufficiency in communication to promote immunisation (2014-2019 cMYP).

2- Personnel and human resources

At all levels of the health pyramid:

- Lack of human resources (in quantity and quality) at all levels of the pyramid, especially lack of personnel specialised in supply chain and logistical management;
- The low level of remuneration for and low level of motivation among health human resources, as well as the non-equitable distribution in the country of the various categories of health professionals at all levels (general report on the census of MOH personnel, 2011);
- The low level of execution of activities for capacity building for the EPI human resources. It has been noted that there are workers untrained in EPI management, especially at the health facility level (90%) and that formative supervision at the region, district and health centre level (46%) is inadequate (2013 EPI External Evaluation).

At the community level

- The 'vertical' use of community health workers by interventions or programmes.
- The low level of integration of immunisation into the intervention package implemented by the CHWs.

3. Procurement & supply chain management system

At the national level:

- The low capacity of vaccine storage at the central level and the fact that the EPI does not have its own storehouse for consumables;

- Dysfunctions and breakdowns in the cold rooms;
- Weak capacity in vaccine stock and supply management, leading to a high wastage rate;
- Absence of a Logistics Management and Information System (LMIS).

At the region and district level:

- The low level of availability of certain vaccines and other inputs, along with frequent shortages at the health facility level. The main factors that prevent quality immunisation services from being provided on a regular basis are weak capacity in supply chain management; insufficient means of transport, especially at the district and health area level (vehicles and motorbikes); and the absence of a Logistics Management and Information System (LMIS) (2013 report on the cold chain equipment inventory; 2013 report on the Effective Vaccine Management assessment).
- The weak level of coverage of needs in logistics required for providing primary healthcare to remote or marginalised populations (2013 report on the cold chain equipment inventory; 2013 report on the Effective Vaccine Management assessment).
- Low capacity of consumables storage, especially in the Littoral Region;

- Other problems in the EPI are presence of refrigerators that do not meet PIS/PQS standards in 25% of health facilities, absence of a maintenance programme for the cold chain in 70% of the HFs and for the buildings in 80%, lack of an adequate system of waste destruction in 73% of the health facilities and lack of a preventive maintenance programme (2013 EVMA).
- Poor management of immunisation waste materials.

4- Health information systems

At all levels of the health pyramid:

- Absence of a strategic document for the development of an information system;
- Fragmentation of the health information management system (low level of inclusion of data from the various programmes), along with a plethora of data collection tools;
- Low level of production of routine data due to the low level of computerisation of the SNIS at all levels and to the low level of skills and the demotivation of healthcare personnel.
- Inability to generate reliable information that could be used to readjust the programme objectives or to guide the appropriate policy decisions (2013 EPI external review report);
- Low level of ability of the managers to use the health information for action or decision-making.

5 Community and other local actors

At the regional and district level

- Low level of involvement by representatives from the community and CSOs in the process of managing child healthcare, including immunisation;
- Low level of participation by administrative and local authorities (opinion leaders, religious leaders, etc.) in supervision of the health community;
- The lack of harmonised strategy for motivating community stakeholders;
- Low level of funding for the production of immunisation promotional material and of educational materials;
- Lack of guidance and coaching for EPI communication focal points;
- Insufficient resources for carrying out community health activities.

6- Political, legal and regulatory environments

- Insufficient application of the principles of accountability and results-based financing (2012 report on health and the health system in Cameroon) at all levels.

7- Community and Health Systems Financing

At the national level

- The low level of State financial contribution to immunisation operations (12% in 2013: 2013 activity report and 2014 AWP). Indeed, the majority of activities are carried out thanks to outside financial support.

- Insufficient funding for implementing all the EPI financing.
- Delays in the availability of funds from the State financial contribution for the purchase of vaccines.
- The delay in sending support documents by the operational and regional levels to the central level lengthens the time before support funds for immunisation services are available to these levels.

At the regional and district level

- Inadequate mechanisms for the securing, allocation, use and justification of funds by service providers;
- Lack of understanding of the local mobilisation mechanisms by the community stakeholders and the CSOs;
- Inefficient use of available resources for healthcare, which leads to significant geographical inequities in terms of access to and use of healthcare services.

8- Programme management

At all levels

- Non-optimal management of the material, human and financial resources programme (cMYP 2016-2019), due to i) the weak managerial capacity of the EPI, especially at the central and regional level; ii) the low level of coordination of activities at the regional and district levels; and iii) the low level of motivation of the personnel, in particular at the operational level.

ACTION UNDERWAY TO REMOVE THE BOTTLENECKS

Cameroon does not have, strictly speaking, a health system strengthening programme with a strategic multi-year plan and action plans produced every year. During the 2001 to 2015 period, the HSS activities were carried out through the 'making the health district sustainable' component of the sectoral strategy. However, this aspect is taken into account in the new 2016-2027 Sectoral Health Strategy and is part of the 'Governance and institutional support' programme, with the following specific objectives:

- Ensure the availability of infrastructures and equipment up to standards in 80% of the health districts and regions, as well as at the central level, between now and 2027;
- Increase the availability and use of quality medicines by 50% between now and 2027;
- Increase the availability of quality HRH by 50% in 80% of health districts and regions, as well as at the central level, between now and 2027;
- Reduce the direct payments to households by at least one third, via an equitable and sustainable financing policy;
- Ensure the availability of 80% of quality health information to all levels of the health pyramid between now and 2027.

It is essentially the State that is carrying out the specific actions underway to remove the health system bottlenecks preventing attainment of optimal coverage for high-impact interventions including immunisation. It does so by implementing sectoral strategy activities and by supporting partners through the implementation of their projects, which are:

(1) The PBF project supported by the World Bank, via a systemic approach: the PBF, in which the 'fully vaccinated child' indicator and some qualitative indicators related to the supply chain and vaccine logistics are remunerated at the operational level.
(2) The joint programme for implementation of CARMMA (Campaign on Accelerated Reduction of Maternal Mortality in Africa) funded by the World Bank, WHO, UNICEF and UNFPA (Initiative H4+) in their convergence districts. The following bottlenecks are targeted by the interventions: governance in the health sector, healthcare funding, essential medical products and technologies, health human resources, health service provision and, lastly, the health information and surveillance system.
(3) WHO: Support for strengthening the health surveillance system and for strengthening the human resources capacity of the EPI (training logisticians).
(4) CHAI: Support for health system strengthening via reinforcement of the cold chain, in particular the monitoring of temperatures and stock management, equipment inventories, equipment repair and maintenance, and support for new vaccine introduction.

(5) Sabine Vaccine Institute: Support for the funding of immunisation and vaccine independence.
(6) The joint AFD-KFW-GIZ programme, which is the largest in terms of funding allocated to Cameroon, and for which the HSS component can be detailed as follows:
- *Component 1*: Improvement of health system governance (improvement of the national management system of essential medicines, strengthening of the coordination and monitoring of the SHS at the regional level);
- *Component 2*: Improvement of the accessibility and the quality of health services. These include rehabilitation of health facilities, limited construction of housing, health facility equipment, maintenance contracts, subsidies for obstetrical and neo-natal care services, support for the setting up of complementary insurance funds (FR: *mutuelles de santé*), setting up of the system for funding demand (healthcare cheque system,), etc.
- Component 3: Capacity building for MOH coordination and management (support for SHS implementation, funding of a technical monitoring committee of the targeted sectoral programme).

Pooled fund *applicants are required to provide a reference to the relevant section and pages in the National Health Sector Plan which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned from the implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.*

11. Health system bottlenecks to be targeted through Gavi HSS support (*Maximum 2 pages*)

Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.

The targeting of bottlenecks for this Gavi HSS support request was made based on the following criteria: the size of the bottlenecks, the capacity of the recommended solution to remove the bottlenecks and produce results, and the sustainability and feasibility of the implementation of the solutions. Furthermore, criteria such as the EPI's priority for strengthening the immunisation system, the eligibility for Gavi support, complementarity with other interventions already underway (in terms of geographical extension) were used.
The bottlenecks were targeted so as to act both on the determinants of immunisation coverage (Tanahashi) and the pillars of the health and community systems.

This way, cash support from Gavi for the HSS will provide priority help in removing the following five sub-groups of bottlenecks:

1. Bottlenecks related to the provision of services:

- Low level of immunisation coverage for most vaccines (Penta3, YFV and MCV);
- Inequitable access to quality immunisation services.

These bottlenecks affect the taking into account of all the target populations (access to immunisation as a human right).

2. Bottlenecks linked to the vaccine supply chain and logistics

- Weak storage capacity for vaccines;
- Weak capacity in vaccine stock and supply management;
- Absence of a Logistics Management and Information System (LMIS);
- Low level of availability of some vaccines and inputs;
- Low level of coverage of needs in logistics required for the provision of primary health care for remote or marginalised populations;
- The presence of refrigerators that do not meet PIS/PQS standards; Poor management of immunisation waste materials.

These bottlenecks affect the availability of vaccines and inputs.

3. Bottlenecks linked to immunisation demand and community commitment

- Low level of involvement by representatives from the community and CSOs in the process of managing child healthcare, including immunisation;
- Low level of funding for the production of immunisation promotional material and of educational materials;
- Insufficient resources for carrying out community health activities.

These bottlenecks affect the adequate and effective use of immunisation services.

4. Bottlenecks linked to data and data quality

- Absence of a strategic document for the development of an information system;
- Fragmentation of the health information management system (low level of inclusion of data from the various programmes), along with a plethora of data collection tools;
- Low level of production of routine data due to the low level of computerisation of the SNIS (National System of Health Information) at all levels;
- Inability to generate reliable information that can be used to readjust the programme objectives or to guide the appropriate policy decisions (2013 EPI external review report);
- Low level of data feedback from the operational to the peripheral level.

These bottlenecks affect the monitoring of immunisation activities and the use of factual data to improve immunisation coverage and equity.

5. Bottlenecks related to programme management and coordination

- The low managerial capacity of the EPI;

- The low level of EPI coordination of activities at the regional and district levels;
- The weak motivation of the personnel, especially at the operational level;
- The vertical nature of the various State programmes and partners in the health sector;
- The weak level of harmonisation/alignment of interventions/service provision at the operational level.

These bottlenecks affect the overall performance of the programme in terms of reaching the immunisation coverage targets set for all the vaccines.

Pooled fund *applicants are <u>not</u> required to complete this question.*

12. Objectives of the NHSP and application (*Maximum 2 pages*)

*Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/strategies being implemented. These objectives must be listed in the same order in **Attachment #6** - Detailed workplan, budget and gap analysis.*

***Pooled fund** applicants are not required to prepare separate objectives; they may instead list the key objectives from the NHSP, including ones relevant to immunisation.*

Objectives	Description
Objective 1: Between now and 2021, improve the accessibility of quality immunisation services, especially for the vulnerable populations in 34 health districts.	This objective is in line with strategic theme 5.2.2. **'disease prevention'** of the 2016-2027 Sectoral Health Strategy. It is linked to the immunisation system component 'provision of services' of the 2015-2019 cMYP. The bottlenecks that we will seek to remove here are: the low level of immunisation coverage, especially for Penta3 and MCV, and the inequitable access to quality immunisation services. Gavi support will target the health districts with special populations in terms of: geographical accessibility; insecurity; or presence of Pygmies, nomads or other groups of marginalised populations. With regard to the 34 health districts where people do not have access to immunisation because of difficulties in geographical access, specific lifestyles or their marginalisation in rural or suburban zones, the Gavi support will make it possible to implement suitable strategies to reach each target, such as outreach and mobile strategies and intensified immunisation activities. Various components of the RED approach will be reinforced for this purpose. The prioritisation criteria for these HDs are as follows: • HDs with special populations in terms of geographical accessibility; insecurity; presence of Pygmies, nomads or other groups of marginalised populations. • HDs with a high number of non-vaccinated children or a low level of coverage in Penta3. To avoid duplication, the HDs that are implementing PBF or that receive other funding for health system strengthening interventions (H4+ or other) will be excluded from this prioritisation. The table of the priority 34 HDs is shown below.

Centre	Littoral	Northwest	West	South	Southwest
Soa	Ndom	Bali	Baham	Ambam	Fontem
Monatele	Nylon	Mbengwi	Batcham	Djoum	Nguti
Ngog mapubi	Abo	Bafut	Galim	Kribi	Akwaya
Yoko	Banguè	Oku		Ebolowa	Konye
Mbandjock	Melong	Batibo		Lododorf	Wabane
	Japoma	Wum			
	Bonassama	Ndu			
	New Bell	NWA			

The districts where insecurity is rife due to the Boko Haram sect or to the war in CAR already receive considerable support in humanitarian aid from the Government and its partners. These are mostly health districts of the northern and East regions. Furthermore, as these regions are the poorest of the country, they also receive development assistance (H4+ initiative for district health system strengthening, and the World Bank more generally for fighting poverty and for PBF).

This objective will make it possible to improve immunisation coverage and

	geographical equity.
Objective 2: Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain.	This objective also is in line with strategic theme 5.2.2. **'disease prevention'** of the 2016-2027 Sectoral Health Strategy. It is linked to the immunisation system component 'supply in good-quality vaccines, logistics and cold chain' of the 2015-2019 cMYP. It also closely follows the recommendations of the last EVM assessment in 2013. It seeks to remove bottlenecks linked to the vaccine supply chain and logistics. Objective 2 will enable better availability of cold chain equipment, better availability of quality vaccines at all levels and a reduction in wastage. Eventually, all the Gavi immunisation outcomes will be improved by the existence of a good cold chain.
Objective 3: Between now and 2021, reinforce involvement by community stakeholders and CSOs in immunisation promotion.	This objective is also in line with strategic theme 5.2.2. **'disease prevention'** of the 2016-2027 Sectoral Health Strategy. It is linked to the immunisation system component 'communication and generation of demand' of the 2015-2019 cMYP. It will make it possible to remove the bottlenecks linked to the generation of immunisation demand and community commitment. Objective 3 will help to stir up demand and to promote the continued use of immunisation services, and eventually to reduce the dropout rates of Penta1-Penta3 and BCG-MCV/MR1. It will also make it possible to improve equity in access to immunisation services insofar as the action will be carried out in 34 targeted health districts based on constraints in terms of equity in access to healthcare (i.e., geographical distance; insecurity; marginalised and disadvantaged populations, etc.) and of low level of immunisation coverage (Penta3). The capacities of community and CSO stakeholders in advocacy and immunisation promotion will be reinforced. Various communication channels will be used to increase awareness of the need for immunisation in the communities, by eliminating the socio-cultural barriers that further non-vaccination or partial vaccination of children.
Objective 4: Between now and 2021, strengthen the Health Information System and data collection at the national level.	This objective is in line with strategic theme 5.2.4. **'health system strengthening'** of the 2016-2027 Sectoral Health Strategy. It is linked to the 'programme management' component of the 2015-2019 cMYP. It is also built onto the plan to improve EPI data quality. It seeks to remove the bottleneck linked to the collection and quality of data at the national level. The idea is to improve the availability and use of quality data, as much for the EPI as for the other health services, through strengthening of the SNIS. Meeting Objective 4 will enable better management of the health information in the country, better monitoring and performances of the EPI in the more general framework of the NHSP, better planning of resources and better strategic planning for the country. It will also enable Gavi better monitoring of performances and investments (performance framework).
Objective 5: Between now and 2021, improve the management and coordination of the programme.	This objective is in line with strategic theme 5.2.5. 'governance and strategic management of the health system' of the 2016-2027 Sectoral Health Strategy. It is linked to the components 'programme management' and 'capacity building' of the 2015-2019 cMYP. It closely follows the recommendations of the September 2015 evaluation of Gavi financial support to Cameroon. It tackles the weak managerial capacity of the EPI, especially at the central and regional level, the low level of coordination of activities at the regional and district levels, and the low level of motivation of the personnel, in particular at the operational level. Proper execution of the activities related to it will enable optimisation of the EPI resources, improvement of the immunisation system processes, and achievement of better performances. This theme will also help improve collaboration and alignment with the various stakeholders of the health sector with which the EPI interacts.

13. Description of activities (*Maximum 3 pages*)

Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in ***Attachment #6*** *- Detailed budget, gap analysis and work plan.*

Pooled fund *applicants are <u>not</u> required to complete this table, but should provide relevant sub-sections of the NHSP focusing on immunisation, including the annual workplan, activities and budget;* ***Attachment #34****: Work plan and annual budget of Pooled Fund and related Terms of Reference*

Objective / Activity	Explanation of link with improving immunisation outcomes
<u>Objective 1</u>: Between now and 2021, improve the accessibility of quality immunisation services, especially for the vulnerable populations in 45 [sic] health districts.	
Activity 1.1: Support the development of microplans for the health facilities in 34 targeted HDs.	This activity will be preceded by a counting of households in all the target HDs, in order to solve the 'denominator' problem. This will make it possible to take into account all the populations with right to immunisation services, to set the targets to reach and to carefully follow the performances in terms of whether or not the set objectives are met for various vaccines. A service provider (National Institute of Statistics) will be prequalified for this purpose. The idea is to reinforce the operational planning in the targeted districts. A training workshop for the stakeholders of HDs that are targeted for microplanning will take place over three days in 2017. It will be followed by an annual workshop for working out the microplans over three days at the health area level, and for consolidation at the district and regional level. This bottom-up planning will make it possible to identify the resources required to reach all the target populations, including the most vulnerable and marginalised who live in remote or poorly served zones. Priority will be given to outreach and mobile strategy healthcare, or any other innovative and effective strategy that can touch the targets not being reached. This includes intensified immunisation activities if needed. The EPI has already carried out microplanning workshops in the past, both for systematic immunisation and for supplementary immunisation activities (SIA for polio in 2014 and measles in 2015), with WHO support. Consequently, Cameroon has the tools and necessary expertise to carry this out rapidly. Good microplanning based on the 'reach every target' principle will make it possible to improve immunisation coverage and equity.
Activity 1.2: Support the carrying out of at least 60% of the immunisation sessions planned as outreach and mobile strategies in the 34 targeted districts.	On average, 50% of the immunisation target population lives more than 5 km or more than one hour's walking distance from a health facility providing immunisation services. This activity will make it possible to extend the immunisation services offer to remote and/or distant populations. Every month, four outreach strategy sessions and one mobile session, with technical and community personnel in attendance, will be held in each of the targeted health areas. The Gavi support will thus help to improve the rate of carrying out care planned as outreach or mobile strategies, in order to reach a broader immunisation target. This will imply better use of immunisation services, which will lead to an increase in immunisation coverage for all the vaccines and a decrease in specific and overall drop-out rates.
Activity 1.3: Support the implementation of at least 60% of the integrated formative supervisions planned by the 34 targeted districts for their health areas.	The formative supervisions will enable regular onsite training, feedback and follow-up of the healthcare personnel, so as to improve their skills as well as the operational capacity of the services that are key factors in immunisation success. In each HD, a supervision team will be set up. These persons will be in charge of supervising each HA monthly. The supervision teams of the districts will visit the health areas at least once per quarter, to help in planning, budgeting, monitoring, training and the problem-solving method, this according to the directives of the national supervision guidelines. The expertise and technical assistance of the AMP, which is already present in some HDs, will be required for this purpose. This will eventually make it possible to improve not only the availability and quality of the services offer, but also the satisfaction of the beneficiaries and consequently the immunisation outcomes, as the quality of care is a key determinant in service coverage.

Activity 1. 4: Provide capacity building for the EPI service providers on the RED approach in the 34 targeted HDs.	This capacity building for the 34 targeted HDs is justified by the constant renewal of healthcare personnel at the operational level, especially in the isolated, rural or insecure zones. It will be carried out via training sessions for immunisation teams that will be rounded out by onsite formative supervisions. Capacity building for healthcare personnel is a positive factor of improvement not only in terms of availability of quality personnel, but also of access to services within the more overall framework of improvement of immunisation coverage.
Objective 2: Between now and 2021, strengthen the logistical and performance capacities of the EPI supply chain.	
Activity 2.1: Purchase the equipment for the cold chain, the wastes management and transport logistics at all levels of the health pyramid.	The 2013 assessment of vaccine management (EVM) highlighted the weaknesses in the nine criteria and categories compared to the 2010 assessment. Efforts have been made to strengthen capacities for storage at the central level and in one region, with support from the ELMA fund. Despite these efforts, the storage and infrastructure capacity remains below standard compared to a good-performing system of vaccine and input management. Based on international recommendations and in accordance with the needs identified during the 2015 cold chain inventory (see attached report) the Gavi support will make it possible to purchase: - 900 solar refrigerators (Dometic, TCW 2000 SDD) over five years, - seven 40m^3 cold rooms for the central and regional level, - three 40kW emergency generators, - 15 Toyota double-cabin pick-up trucks, - 452 125cc Yamaha AG5 motorbikes, - 40 120kg gas cylinders for the incinerators purchased with the C2D fund, - 40 incinerators, - 14 voltage regulators for the central and regional cold rooms. These purchases will make it possible to store all the vaccines, diluents and injection material needed for the national immunisation programme, as well as to improve the availability of quality vaccines, the supervision of the vaccine management, and injection safety, especially in the targeted districts. This will enable the EPI to improve the quality of the supply chain and vaccine logistics, and to ensure the quality of the vaccines for quality immunisation.
Activity 2.2: Ensure that equipment functions properly throughout its useful life.	The cold chain and logistics are key aspects of the immunisation system, and their maintenance is primordial for ensuring the quality of the vaccines. The Gavi HSS grant will support this initiative for the equipment that will be purchased, as the cost of the preventive maintenance is included in the purchase cost. This will make it possible to ensure that the continuity of services is not compromised by recurrent breakdowns. The proposal will thus fund: - The proper functioning of the equipment, notably via a maintenance contract for the cold chain equipment; - The monitoring of the cold chain temperatures throughout the supply chain, via the purchase of 3000 temperature control tools; the purchase and installation of RTMDs for the 12 central and regional cold rooms not currently covered; and the purchase of 6000 freeze indicators.
Activity 2.3: Improve skills of the personnel involved in vaccine management at all levels.	This activity will ensure good availability of quality vaccines via the setting up of a pool of national trainers, the revision of the 'norms and procedures of supply chain management' document, as well as the development of training modules to train service providers in all the districts thanks to the Gavi HSS funding and to other partners. This proposal will fund: - A regional workshop for the training of two DMTs in each of our targeted 34 districts, over three days; - A workshop at the district level to train one participant for each targeted health area, over four days.
Activity 2.4: Manage two innovations: the computerised management of stocks and a 'redesign' of the distribution system in order to optimise it.	To become modernised, the EPI will have to make progress on two fronts: a) Set up a real-time inventory system and an online database for monitoring stock and the performance indicators related to logistics and the cold chain. b) Evaluate the vaccine distribution system in Cameroon. Currently, the districts supply themselves from the regional level, and the health areas from the district level. The reversal of this distribution chain into a system in which the regions serve the districts and the districts serve the health areas (a true 'redesign') will have several advantages: - Ensure regular distribution to the lower levels of vaccine stocks; - Accompany vaccine distribution to the lower levels with sessions on formative supervision, preventive maintenance and even equipment inventory.

	The Gavi support will consist in testing these two innovations, by financing: - For the computerised management system: The development of a tool to improve logistical information systems (support from a specialised consultant), then the management of this new tool in a region; - For the redesign of the distribution chain: The evaluation of existing logistics management, followed by the setting up of a pilot intervention that changes the flow of the current distribution system. For these two interventions, the Gavi funding would cover only the pilot phase. The EPI will then arm itself with the results and recommendations in order to look for appropriate funding to spread these new tools to other regions.
<u>Objective 3</u>: Between now and 2021, reinforce involvement by community stakeholders and CSOs in immunisation promotion.	
Activity 3.1: Establish partnerships between the health structures and the CBOs, local associations (LAs) or other community groups in the 34 targeted health districts.	This involves establishing a strategic partnership among the CBOs, LAs, community groups and community health workers involved in promotion of immunisation services, and the health facilities, so that they can participate in the planning and organisation of immunisation activities as well as carry out community mobilisation activities in the field. These latter particularly include awareness-raising targeting the community leaders and families, and the search for those who are lost to follow-up. This activity will help improve demand for and acceptance of immunisation (will reduce the numbers of those not reached and of those who do not return). Immunisation coverage and equity will thereby be improved. Concretely speaking, the proposal calls for funding: (1) Identification of the CBOs, LAs, community groups and community health workers who are interested and/or involved in the health service activities, including immunisation. A consultant will be recruited for this purpose (service costing US$ 8000). (2) The mapping of the actors will be validated at the central level during a meeting with 40 participants from the EPI, and civil society organisations will be identified. (3) The implementation of community activities in the 34 priority HDs. It will be guided by the performance monitoring of the districts, based on data broken down by community. This will involve supporting home visits (IEC and looking for those who are lost to follow-up) and awareness-raising for community leaders by the CSOs under contract.
Activity 3.2: Capacity building in immunisation promotion for the stakeholders in charge of communication and the service providers working on immunisation promotion in the 34 targeted HDs.	In reference to the EPI communication plan, capacity building in Communication for Development (C4D) is an absolute necessity for the success of the 'communication and generation of demand' component of the 2015-2019 cMYP. This activity will help to significantly improve the capacities of the community stakeholders and the service providers in charge of immunisation. Several types of training will be provided in 2017 and in 2019: (1) training in C4D and in immunisation promotion for the members of the dialogue structures of the health services, the CBOs, the LAs and the community groups. This training for 15 persons per target district will take place over two days. (2) training in immunisation promotion and in interpersonal communication for the immunisation service personnel. This two-day training will concern two persons per target health area. (3) two-day training in the community score card approach for 12 regional and central facilitators. This card will make it possible to monitor both activities for generating demand and community commitment. (4) These regional and central facilitators will in turn train the management teams of each target district (five persons per district over two days) in how to use the community score, so that they themselves can ensure the quality of community actions on a monthly basis. This training will act positively on the family-related factors that are key to immunisation success. They will lead to better information and awareness in favour of immunisation, to trust in the health system and immunisation services, as well as to better cultural acceptance. They will also have positive impact on community participation, which will

	increase. All this will aid in awareness of the need for immunisation and consequently a decrease in the number of targets not reached or in those lost to follow-up. And it will eventually lead to improvement in immunisation coverage and equity, and in the decrease of the specific and overall drop-out rates.
Activity 3.3: Support the advocacy activities to promote sustainable funding for immunisation.	To strengthen the capacities of the civil society stakeholders and the media, it will be necessary to: 1) Train the media in production and broadcast of shows and microprogrammes on immunisation issues. Two persons per target district will be trained over two days. 2) Train the leaders of civil society in advocacy for community acceptance of immunisation; in immunisation funding; and in the organisation, implementation and performance of the immunisation system according to the model of the AMP's 'ADVIM' programme, which is given in West Africa and lasts about five months. 3) Organise special events with celebrities (artists, musicians, football stars) to promote immunisation as a fundamental right. The budget provides for the funding of two immunisation symposiums over two years (for a total price of US$ 16,660), in 2017 and 2019. These special training sessions and events will have to enable the CSOs and media not only to plead in favour of universal methods to guarantee good-quality immunisation in the entire country, but also to reinforce the capacities of the communities so that they can ensure increase in the demand and social acceptance of vaccines and the reinforcement of the provision of immunisation services.
Activity 3.4: Support for duplication costs of communication material for increasing people's awareness in the 34 targeted HDs.	The duplication of communication material for awareness-raising targeting the general public (Guidebook for the EPI social mobiliser, image box, giant banners, panels, posters, pamphlets for mothers) will be financially supported by Gavi in the 34 targeted HDs and by other partners in the rest of the HDs. It will be accompanied by radio and TV publicity spots broadcast in the 34 districts. This communication material to promote immunisation will help facilitate activities to generate demand for immunisation and to ensure a good level of coverage for all the vaccines. Indeed, it will help reduce the lost opportunities and the number of children not reached or who are lost to follow-up. • The production of this communication material (mainly printing costs to cover all the target districts) will cost US$ 194,000 over five years. • The dissemination costs (radio/TV spots and costs for putting up posters) will be US$ 218,000 over five years.
Activity 3.5: Ensure the monitoring and evaluation of the communication activities/KAP survey.	This activity will make it possible to produce good-quality information in order to assess the impact of communication in the programme and to take the appropriate decision in this area. Related tasks include: (1) Carrying out satisfaction surveys and organising quarterly meetings in 34 districts to implement the community score card in the targeted districts for verifying the quality of services and (2) carrying out two KAP surveys on immunisation.
Objective 4: Between now and 2021, strengthen the Health Information System and data collection at the national level.	
Activity 4.1: Support the setting up of an integrated and functional national system of health information (SNIS).	The DHIS2 tool is currently being set up nationwide and will come into effective use in 2016. The activities related to it are carried out at the MOH's Health Information Unit level, along with technical and financial support from WHO. Special emphasis will be placed on harmonisation of the parallel systems of sending data and the electronic input of data, And on the integration and inter-operability with the other data management systems of routine immunisation (DVD-MT) and logistics (SMT). [TRANSLATOR'S NOTE: *lacuna in the FR version of this sentence.]* Gavi support for this activity will be carried out through: (1) training of data managers in the DHIS2 tool (collection and analysis of data linked to the annual reviews of the sector and the annual reviews of the EPI). This training will concern two persons per region and per health district over three days, divided into three training pools. (2) making monthly tools for data collection and reporting available in the 34 targeted

	HDs, at a cost of US$ 8 per district. (3) Payment in the 34 target HDs for Internet connection fees (US$ 42 per month) and for the purchase of one Internet modem per district at a cost of US$ 100 (renewed after three years). (4) A consultant to ensure inter-operability between the DHIS2 and the other systems (SMT, DVD-MT, MAR). This activity will, among other things, make it possible to avoid the redundancy of several sub-systems of parallel information without interconnections between them, to harmonise the numerous data-collection tools and to propose a common strategy for collection and use of health data. It will be carried out in cooperation with other partners (WHO and UNICEF) already involved in the process of modernising and strengthening the SNIS, as well as potential partners such as the Bill and Melinda Gates Foundation and PATH via the 'Better Immunization Data[1]' Initiative, in whose network Cameroon is a member. The funding for computer equipment will come from State resources. The technical assistance will be paid by the EPI partners (WHO, CHAI, Gavi, etc.). Developing an integrated information system that includes management of vaccines, cold chain equipment and logistics will make it possible not only to improve the availability, quality and fair distribution of vaccines throughout the country, but also to reduce the workload of the personnel (already insufficient [sic]) at the operational level. Removing this burden will increase the amount of time data is used for actions and consequently the identification of the non-vaccinated targets. This activity will help decrease the drop-out rate and to increase the immunisation coverage of all the vaccines.
Activity 4.2: Support the implementation of activities stemming from the evaluation of data quality.	Gavi's support for action to improve data quality will involve: (1) Support for organising quarterly meetings to analyse and validate data in the country's 189 HDs. One person per HA as well as three persons per target HD will participate in these one-day meetings. (2) Support for organising half-yearly regional meetings to analyse and validate data, including those of immunisation, by including in them the implementation status of PRP ensuing from the DQS supervisions in the 10 regions of the country. These half-yearly meetings will bring together three participants per region and one from each targeted HD, as well as a central facilitator per region, for a three-day session. (3) Training in 2017 for the management teams of the districts, in the data quality standards and in supervision with the DQS tool. It will be attended by two persons per target HD, three persons per target region, and one central facilitator. (4) Support for the organisation of annual peer evaluations using the DQS tool at the district and health area levels. These evaluations will be carried out in each of the six targeted regions by one evaluator for three target HDs and two regional evaluators. (5) The carrying out of independent evaluations on the quality of immunisation data nationwide, with one evaluator per region (DQA or DQRC). The aim of this activity is to monitor the progress made in improving the quality of data at the immunisation services level. Likewise, it will make it possible to determine the accuracy of the number of reported vaccinations and the quality of the immunisation monitoring system, to make sure that the management of immunisation services and the allocation of funds allotted for this purpose (allocation of Gavi funds) are based on reliable and accurate data.
Activity 4.3: Carry out surveys and evaluations of the health sector, with emphasis on the immunisation system.	Gavi support will focus on the monitoring and implementation of the NHSP and the carrying out of specific surveys at the EPI via institutionalisation of the following evaluations: (1) The annual review of the health sector, together with the DQA or DQRC, using one evaluator for each of the 10 regions over 12 days (including briefing, fieldwork collection and debriefing). (2) The evaluation of the health structures every two years (to determine whether they are prepared to ensure immunisation services and other health services, in particular in

[1] www.BIDinitiative.org

	terms of availability of personnel and resources). This proposal would involve conducting a SARA survey accompanied by the DQRC in 2017, 2019 and 2021, with a unit price of US$ 80,000. (3) The external review of the EPI every two years (in 2017 for the cMYP revision and in 2021 for developing the 2021-2027 NHSP), with one evaluator for six regions over 12 days (including briefing, fieldwork collection and debriefing). (4) The national surveys for immunisation coverage together with identification of the factors associated with non-vaccination in the low-performing HD and with an equity examination (every two years), using 8 national evaluators and six regional evaluators over three days in 2017, 2019 and 2021. (5) The implementation of the operational research, costing US$ 116,000 in 2018 and 2020. The subjects of this research will depend on the priorities observed by the EPI (e.g., on the introduction of new vaccines). (6) The evaluation of communication activities, through the carrying out of two KAP surveys on immunisation in 2018 and 2020. These evaluations will strengthen monitoring and evaluation and will make it possible to use the available information for strategic planning based on factual data. This will help improve the immunisation outcomes.
Activity 4.4: Support the production of the statistical yearbook.	Gavi support will consist in funding the production of the health data and statistics yearbook every two years. A service provider will be pre-qualified for this purpose (NIS). The availability of the health information will facilitate its access and use for enlightened decision-making at the strategic level. This yearbook will be accessible on the MOH website.
Objective 5: Between now and 2021, improve the management and coordination of the programme.	
Activity 5.1: Support EPI planning	Good planning for the programme is the foremost pillar for improving the rate of national coverage. The proposal therefore provides for support to: - Updating the 2015-2019 cMYP in 2017, through a five-day workshop that will bring together the national and local stakeholders. The 2015-2019 cMYP currently being implemented was in fact developed before the 2016-2027 Sectoral Health Strategy. Furthermore, it does not contain a monitoring and evaluation plan. Its updating will make it possible to bring it up to date, improve the M&E framework, and work out a realistic M&E plan in line with the M&E of the NHSP according to the IHP+ directives. - The workshop to develop the 2020-2024 cMYP, in 2019, through a five-day workshop bringing together the national and regional stakeholders. Finally, to guarantee good governance for the programme, the manual of procedures will also be updated in 2019, after a two-year simulation phase.
Activity 5.2: Support the coordination meetings at the regional and district levels.	By reinforcing the organisation and providing technical and financial support to the functioning of the coordination bodies already existing at the regional level, the representativeness of all the agencies/bodies working in immunisation will be improved. Immunisation will thus be a priority point in the agenda of the regional and health district coordination meetings, which moreover will act as a subnational body for monitoring, evaluation and accountability for immunisation. The proposal calls for support for: - One meeting for each of the six regions, in which one person for each of the 34 priority districts participates, twice per year. - One meeting for each of the priority districts, in which two persons per health area participate, twice a year.
Activity 5.3: Carry out two Gavi HSS evaluations (mid-term and final).	The mid-term and final evaluations of the HSS will make it possible to ensure the efficient and transparent management of the Gavi HSS grants. They will moreover make it possible to provide information needed for: (1) The progress report on the next cycles of HSS and EPI planning; (2) assessment of the progress made towards achieving immunisation outcomes; (3) assessment of the effectiveness and efficiency of the various financial grants and of the technical assistance intended to strengthen the health

	system in general and the subsystem of immunisation in particular. These evaluations, which will cost US$ 100,000[2] each, will be conducted in 2019 and 2021.
Activity 5.4: Cover management costs for the Gavi HSS programme, including the financial audits.	The Gavi support for this activity will make it possible to ensure management that is responsible, transparent and in accordance with the EPI manual of procedures. It will annually fund the following operations: (1) The operating costs of the HSS programme, estimated at 3% of the proposal's budget; (2) An annual internal audit mission, led by three persons per region for 10 days, and one regional accounting manager for seven days; (3) A workshop for annual validation of the EPI financial statements, with all the regional accounting managers, for six days; (4) An annual external audit, costing US$ 15,000.
Activity 5.5: Support the capacity building of personnel from the TAG-EPI and the EPI regional units (URPEV).	This activity will consist in: (1) Training the leaders of the TAG-EPI in strategic management and public finances (two persons per year, chosen from among the EPI section heads and the heads of the regional units). (2) Training the EPI personnel of all levels in immunisation programme management (MLM) and in management of the vaccine supply chain and logistics, with a view to improving their management skills for better EPI performance (two persons per target district, two persons, 10 central participants, for a 10-day session).
Activity 5.6: Provide technical assistance for EPI manager capacity building.	The technical assistance will improve the management capacities of the EPI and will enable skill transfer in the field of studies to be carried out as part of EPI monitoring and evaluation and of operational research.
Activity 5.7: Improve the motivation of the immunisation teams at the operational level.	The routine immunisation data of 2015 have shown a big drop in immunisation indicators in some of the HDs of the country. Out of the 14 HDs concerned, 11 are HDs of the Far North region. This phenomenon is due to the rampant insecurity in the region in recent months. The appeal of positions and the motivation of personnel have decreased steeply in most of these HDs, resulting in an overall drop in performances. This activity will consist in reinforcing the systems for giving incentive to personnel performance. It will come in addition to commitment from the Government and from partners in the form of extension of the PBF or 'payment according to results obtained' in this vulnerable area. The idea is to use it as in instrument to give the service providers a 'stake' in maximising their efforts to achieve the best results possible both in immunisation and in the other mother-child health interventions. Based on performance contracts signed between the service providers and the contracting agencies, the financial incentives are going to lead the service providers to carry out immunisation activities that meet norms and standards, and to find innovative and appropriate solutions to reach every target and catch up with those lost to follow-up in the area they are responsible for. The quantity of services in terms of number of targets reached and the quality in terms of the operational capacity of the immunisation services will be improved. The maximum amount of allowances per year would be US$ 3,012,109. This figure was calculated according to the indicators to purchase (see attached document regarding this intervention).

[2] Gavi Guidelines (2015), Attachment 2: arrangements for monitoring and evaluation, page 67.

14. Results chain (*Maximum 4 pages*)

*Complete the **Results Chain** using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.*

*Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org*

***Pooled fund** applicants are not required to complete this template, but must provide a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP.*

Results chain

Objective 1: **➔Between now and 2021, improve the accessibility of quality immunisation services, especially for the vulnerable populations in 34 health districts.**

Key Activities:	Intermediate Results:	Immunisation Outcomes:
Activity 1.1: Support the working out of microplans for the health facilities in 34 target HDs. **Activity 1.2:** Support the carrying out of at least 60% of the immunisation sessions planned as outreach and mobile strategies in the 34 targeted districts. **Activity 1.3:** Support the implementation of at least 60% of the integrated formative supervisions planned by the 34 targeted districts towards their health areas. **Activity 1.**4 Provide capacity building for the EPI service providers on the RED approach in the 34 targeted HDs.	▪ IR1: Equity in access to immunisation services is strengthened.	▪ <u>Immunisation coverage is increased.</u> Immunisation coverage of Pentavalent3 in the targeted zones Immunisation coverage of MR in the targeted zones Penta1/Penta 3 drop-out rates in the targeted zones ▪ <u>Immunisation equity is improved.</u> Proportion of targeted districts with Pentavalent3 immunisation coverage ≥ 95% Proportion of targeted districts with Pentavalent3 immunisation coverage ≥ 80% Proportion of targeted districts with Pentavalent3 immunisation coverage ≥ 50% and <80%
Related Key Activities Indicators: ▪ AI1.1: % of targeted health districts that have produced their microplan for the routine EPI ▪ AI1.2: % of outreach or mobile strategies carried out ▪ AI1.3: % of formative supervisions carried out ▪ AI1.4: Number of service providers trained in the RED approach	**Related Intermediate Results Indicators:** ▪ Number of surviving infants who received the first recommended dose of the Pentavalent vaccine (Penta1) ▪ Number of surviving infants who received the third recommended dose of the Pentavalent vaccine (Penta3) ▪ Number of surviving infants who received the first recommended dose of the measles vaccine via routine services (MCV1)	

Objective 2: **➔Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain.**

Key Activities:	Intermediate Results:	Immunisation Outcomes:
Activity 2.1: Purchase the equipment for the cold chain, the wastes management and transport logistics at all levels of the health pyramid. **Activity 2.3:** Improve skills of personnel involved in	▪ IR2.1: Availability of cold chain equipment is improved. ▪ IR2.2: Availability of vaccines is improved. ▪ IR2.3: Quality of vaccines is improved.	▪ <u>Immunisation coverage is increased.</u> Immunisation coverage in Pentavalent3

vaccine management at all levels. **Activity 2.4:** Manage two innovations: the computerised management of stocks and a 'redesign' of the distribution system in order to optimise it.		Immunisation coverage in MR ▪ <u>Decrease in children lost to follow-up</u> Penta1/Penta3 dropout rate ▪ <u>Immunisation equity is improved.</u> Proportion of districts with Pentavalent3 immunisation coverage ≥ 95% Proportion of districts with Pentavalent3 immunisation coverage ≥ 80% Proportion of districts with Pentavalent3 immunisation coverage ≥ 50% and <80%
Related Key Activities Indicators: ▪ AI2.1: o Number of cold rooms and refrigerators obtained and operational o Number of incinerators installed and operational o Number of vehicles and motorcycles purchased ▪ AI2.3: Number of personnel trained in vaccines ▪ AI2.4: Number of districts with a computerised system for supply chain management	**Related Intermediate Results Indicators:** ▪ RIRI2.1 : Number of health facilities that immunise and are equipped with an approved and operational cold chain ▪ RIRI2.2a: Proportion of districts having experienced a stock-out in Penta ▪ RIRI2.2b: Proportion of districts having experienced a stock-out in MR ▪ RIRI2.3:Number of alarms reported in the cold rooms	

Objective 3: **➔Between now and 2021, reinforce involvement by community stakeholders and CSOs in immunisation promotion and other child health interventions.**

Key Activities: **Activity 3.1**: Establish partnerships between the health structures and the CBOs, local associations (LAs) or other community groups in the 34 targeted health districts. **Activity 3.2**: Capacity building in immunisation promotion for the stakeholders in charge of communication and the service providers working on immunisation promotion in the 34 targeted HDs. **Activity 3.3:** Support the advocacy activities to promote sustainable funding for immunisation.	**Intermediate Results:** ▪ IR3.1: Community participation to promote immunisation in the 34 targeted HDs is increased. ▪ IR3.2: The population is informed, sensitised and motivated regarding immunisation.	**Immunisation Outcomes:** ▪ <u>Immunisation coverage is increased.</u> Immunisation coverage in Pentavalent3 Immunisation coverage in MR ▪ <u>Decrease in children lost to follow-up</u> Penta1/Penta3 dropout rate ▪ <u>Immunisation equity is improved.</u> Proportion of districts with Pentavalent3 immunisation coverage ≥ 95% Proportion of districts with Pentavalent3 immunisation coverage ≥ 80%
Related Key Activities Indicators: ▪ **AI3.1:** % of health facilities that have signed at least one contract with the CBOs, local associations (LAs) or other community groups for implementation of community activities to promote immunisation in the 34 targeted	**Related Intermediate Results Indicators:** ▪ RIRI3.1: Percentage of CBOs, LAs or other community groups that implement at least 50% of the activities of their contract in the 34 targeted health districts.	

health districts. ▪ **AI3.2:** Proportion of community stakeholders (CBOs, LAs, community groups, dialogue structures, CHWs) and service providers trained in immunisation promotion ▪ **AI3.3:** Proportion of media trained in advocacy to promote the funding and promotion of immunisation	▪ RIRI3.2: At least 90% of persons in charge of target children accept and immunise their children.	Proportion of districts with Pentavalent3 immunisation coverage ≥ 50% and <80% Difference in Pentavalent3 immunisation coverage between poorest quintile and richest quintile Difference in Pentavalent3 immunisation coverage between boys and girls Difference in Pentavalent3 immunisation coverage between children with a mother/guardian who is educated vs. not educated

Objective 4: **➔Between now and 2021, strengthen the Health Information System and data collection at the national level.**

Key Activities: **Activity 4.2:** Support the setting up of an integrated and functional national system of health information (SNIS). **Activity 4.3**: Support the implementation of activities stemming from the evaluation of data quality. **Activity 4.4:** Carry out surveys and evaluations of the health sector, with emphasis on the immunisation system.	**Intermediate Results:** ▪ Availability of vaccines is improved. ▪ Quality of data is improved.	**Immunisation Outcomes:** ▪ <u>Immunisation coverage is increased.</u> Immunisation coverage in Pentavalent3 Immunisation coverage in MR ▪ <u>Decrease in children lost to follow-up</u> Penta1/Penta3 dropout rate ▪ <u>Immunisation equity is improved.</u> Proportion of districts with Pentavalent3 immunisation coverage ≥ 95% Proportion of districts with Pentavalent3 immunisation coverage ≥ 80% Proportion of districts with Pentavalent3 immunisation coverage ≥ 50% and <80% Difference in Pentavalent3 immunisation coverage between poorest quintile and richest quintile Difference in Pentavalent3 immunisation coverage between boys and girls
Related Key Activities Indicators: ▪ Number of districts with at least one employee trained in use of DHIS2 ▪ Proportion of activities carried out from the data quality improvement plan ▪ Proportion of surveys and evaluations carried out	**Related Intermediate Results Indicators:** ▪ Difference (in percentage points) in Pentavalent3 immunisation coverage indicated from administrative data compared to that from an immunisation coverage survey is < 5%. ▪ Speed of EPI Monthly Activity Reports (MAR) from the health districts ▪ Completeness of EPI Monthly Activity Reports (MAR) from the health districts ▪ Completeness of data review reports from the health districts	

	▪ Proportion of health districts that carry out two DQS annually	Difference in Pentavalent3 immunisation coverage between children with a mother/guardian who is educated vs. not educated

Objective 5: **➔Between now and 2021, improve the management and coordination of the programme.**

Key Activities: **Activity 5.1:** Support EPI planning **Activity 5.5:** Support the skill reinforcement of personnel from the TAG-EPI and the EPI regional units. **Activity 5.7:** Improve the motivation of the immunisation teams at the operational level, especially in the highly insecure zones (30 HDs in Far North).	**Intermediate Results:** ▪ IR5: EPI operational management is improved.	**Immunisation Outcomes:** ▪ <u>Immunisation coverage is increased.</u> Immunisation coverage in Pentavalent3 Immunisation coverage in MR ▪ <u>Decrease in children lost to follow-up</u> Penta1/Penta3 dropout rate ▪ <u>Immunisation equity is improved.</u> Proportion of districts with Pentavalent3 immunisation coverage ≥ 95% Proportion of districts with Pentavalent3 immunisation coverage ≥ 80% Proportion of districts with Pentavalent3 immunisation coverage ≥ 50% and <80% Difference in Pentavalent3 immunisation coverage between poorest quintile and richest quintile Difference in Pentavalent3 immunisation coverage between boys and girls Difference in Pentavalent3 immunisation coverage between children with a mother/guardian who is educated vs. not educated
Related Key Activities Indicators: ▪ AI5.1a : Proportion of the annual budget of Gavi HSS funding used during the last semester ▪ AI5.1b: Total amount spent by the CSOs during the last semester ▪ AI5.5: Proportion of EPI personnel trained according to the identified needs ▪ AI5.7: Total amount of PBF allowances paid	**Related Intermediate Results Indicators:** ▪ RIRI5: Rate of carrying out activities from the Annual Workplan (AWP) ▪ Proportion of funds used according to standard	

IMPACT: Decrease in infant and child morbidity and mortality

ASSUMPTIONS

List any assumptions:

- Social, economic and political stability is guaranteed.
- The security situation is improved in the entire country.
- Control of situation concerning refugees from neighbouring countries undergoing conflicts, the evolution of which is currently unpredictable.
- Availability of State funds and funds from other development partners to fill in the programme gaps (supplements and synergy).
- Recruitment, optimal use and loyalty of healthcare personnel are ensured (HR national development plan).
- Good governance and transparency in the overall management of funds conforms to the requirements of Gavi and Cameroon.
- The CSOs, CBOs, LAs and other community groups effectively participate in implementing the programme.
- The technical support from the EPI's traditional partners is maintained.
- The availability of an NHSP and an integrated M&E plan covering the 2017-2021 period.

15. Monitoring and Evaluation (M&E) (*Maximum 2 pages*)

Provide a description of how HSS grant performance will be monitored.

1- Authorities and bodies involved in Monitoring and Evaluation (M&E):

The HSS programme's monitoring and evaluation will be taken care of at the central level by the TAG-EPI, at the regional level by the EPI Regional Units and at the operational level by the health districts through the SNIS mechanisms and tools. To ensure the monitoring and evaluation duties, an expert in M&E (a technically competent high-level manager) will be designated within the body responsible for carrying out the programme at the central level (TAG-EPI).

The SHS Steering Committee expanded to the ICC will take care of M&E coordination. Coordination meetings involving all the stakeholders will take place quarterly. The quarterly reports, validated at the central level by the SHS Steering Committee, will act as the bases for dissemination of the outcomes of the HSS grant.

The SHS Steering Committee and the TAG-EPI will see to it that the present grant is tied as much as possible to the monitoring of the health system strengthening activities of the 2016-2027 Sectoral Health Strategy according to the IHP+ initiative model. Indeed, the activities of Objective 4 related to the integration of the EPI into the SNIS will make it possible to gradually and fully make the EPI information sub-system in line with the SNIS via the DHIS2 tool. Furthermore, the annual EPI review, including the HSS Programme, will be conducted within the overall framework of the annual review of the health sector.

2- Mechanisms and tools used:

Two groups of activities will be carried out: (i) The routine monitoring activities (progress monitoring and performance monitoring), and (ii) the evaluation activities (or strategic monitoring and evaluation).

- *The progress-monitoring activities*: This will concern monitoring implementation of planned activities. The persons in charge of the activities will carry out regular monitoring, with reporting to the management body of the Gavi HSS Programme. The collection and transfer of monitoring data will be carried out with the help of monitoring sheets and execution-of-activities reports after validation at all levels and according to a bottom-up approach. A dashboard will be used at all levels to quickly identify the gaps in implementation, the obstacles, and the abuses. A feedback system will help in taking corrective actions at all levels.

The activities monitoring system will be rounded out by monitoring, supervision and programme-quality-control missions.

- *Performance monitoring activities* (all levels): This concerns monitoring the meeting of objectives. The administrative data will be produced by the health facilities and services according to the action monitoring guidelines for the RED approach. The data collected at the health facility level via physical tools (registers, punch cards for immunisations, stock sheets, wastage monitoring sheets, etc.) will be validated and consolidated in a monthly activity report and sent to the health district for consolidation into the electronic tools DHIS2 or DVD-MT. The data obtained will be analysed at the health facility level. At the district level, data review meetings will give rise to decisions for performance improvement and will be subject to data review reports. These latter will be sent, together with the district's monthly activity reports in printed and electronic versions, to the regional level for validation, analysis and operational decision-making. Once validated by the region as part of the data review meetings, they will be sent to the central level for strategic management. The frequency of sending these data will be monthly at all levels of the health system. A mini-review of the HSS programme will be carried out quarterly at the central level by the team of persons in charge of implementation, along with participation by all the country stakeholders of Health System Strengthening. It will make it possible to take stock of the progress and performances of the programme, and to work out recommendations for improvement of implementation.

- *The evaluation activities*: Studies and surveys outside the EPI combined with administrative data will be carried out. These will include Service Availability and Readiness Assessments (SARA), national surveys (ICS, DHS or MICS), occasional surveys of coverage and household satisfaction, KAP surveys and surveys on coverage and identification of causes for non-vaccination, etc. The funding provided for in this proposal will be used to conduct the immunisation coverage survey planned for 2018 in association with the EPI external review. The other immunisation coverage surveys will be paid for by the State and its partners, via the DHS and MICS surveys planned for 2016, 2017, 2020 and 2021. These activities will be coordinated by the Health Information Unit of the MOH and will benefit from technical and financial support not only from Gavi, but also from the other partners and research institutions of the country. The results of these evaluations will make it possible to take decisions such as the revision of strategic documents of the health sector, priority programmes or plans to improve the performances of health interventions. Furthermore, a mid-term evaluation and final evaluation of the Gavi HSS programme will be carried out in 2019 and 2021 respectively.

3- Data sources used:

The M&E mechanisms of the proposal will be based on the following two data sources, as described in the

performance framework: (1) The administrative data (routine EPI) collected via the SNIS, which is the responsibility of the EPI and the MOH's Health Information Unit, and (2) the data collected from the surveys and studies as well as operational research, etc., under the responsibility of the CIS, in cooperation with the development partners and the country's research institutions, according to the below plan:

Table 2: Survey/evaluation plan

				Gavi HSS				
Surveys/Studies	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Immunisation Coverage					X		X[3]	
MICS	X			X			X	
DHS			X					X
DQRC				X	X	X	X	X
SARA				X		X		X
EVM				X		X		X
Health Sector Review				X	X	X	X	X
EPI external evaluation					X		X	
Satisfaction survey and KAP					X			X
Mid-term HSS evaluation						X		
Final HSS evaluation								X

.

4- Gavi HSS budget allocated to M&E (M&E and Objective 4)

In addition to the periodic monitoring meetings and the quarterly and annual reviews of the programme, the Gavi HSS grant will fund all the activities of Objective 4. The envelope allocated to M&E and Objective 4 cover the activities for progress monitoring, performance monitoring and HSS programme evaluation. The total budget of these activities is US$ 2,115,222. This represents approximately 8.99% of the total budget of the proposal.

5 - Method for carrying out evaluations (mid-term and final)

The mid-term evaluation will deal with the following aspects: analysis of the previous reports on monitoring and on evaluation; verification of the results indicators for the period concerned; analysis of the relevance of the activities planned for reaching the expected outcomes; the report on the use of resources and analysis of the balance between the resources used and the level of outcomes obtained; analysis of the intervention strategies; analysis of the level of involvement and the degree of satisfaction among the beneficiaries (community); identification of the difficulties encountered in executing the project/programme; the proposals, in the form of recommendations, for the various stakeholders, with a view to providing improvements or modifications to the project in order to guarantee that the outcomes of the project are reached.

The final evaluation of the Gavi HSS grant will be independent. It will be commissioned at the end of the grant, in mid-2019. Gavi's evaluation principles (independence, impartiality, sensitivity and participation by stakeholders) and the OECD-DAC evaluation principles will be the governing principles for learning lessons and giving accounts as constructively as possible.

An evaluation committee will be set up with quite precise specifications in order to coordinate the process and guarantee the quality and later use of the evaluation data. Selection of a consulting firm will be carried out by competitive bid for tender. The evaluation committee will see to it that the following key evaluation questions are included in the evaluation: (i) the design of the grant's activities and (ii) the implementation and outcomes of the activities, within the scope of the evaluation. This will be done so that the entire chain of results, from inputs to impact, is taken into account. A high-level presentation workshop will be held to discuss the conclusions, outcomes and recommendations with the main stakeholders, the persons in charge of implementation and the decision-making bodies. With regard to methodology, a mixed approach with qualitative and quantitative methods will be given priority. Technical assistance from Gavi will be requested when the times comes, to support the evaluation committee, especially for defining the specifications of the evaluation, the validation of the methodology and the examination of the evaluation report.

6- M&E of the PBF

The monitoring and evaluation of the PBF aspect will be carried out within its overall framework, via the PAISS monitoring and evaluation mechanisms. Nevertheless, the monitoring of the EPI indicators that will be subject to

[3] This coverage survey will be accompanied by the 2020 MICS and funded by the State and UNICEF.

purchase depending on performance in the 30 HDs of the Far North Region will be transferred to the level of specific monitoring of the HSS programme, according to the outcome framework produced in the concept note (***Attachment 30***).

16. PBF Data Verification Option	
Choose which data verification option to be used for calculating the performance payments.	
Data verification option	**Select ONE**
Use of country administrative data	☒
Use of WHO/ UNICEF estimates	☐
Use of surveys	☐

PART D: WORKPLAN, BUDGET AND GAP ANALYSIS

17. Detailed workplan, budget narrative and gap analysis (*Maximum 3 pages*)

*Complete **Mandatory Attachment #6**: Detailed workplan, budget and gap analysis, which can be accessed at the online country portal. Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.*

1- Description of the budget

Implementation of the HSS Programme for the 2017-2021 period will require overall funding of **US$ 23,520,000**, or an average cost per year of **US$ 4,704,000**. There will be an equal breakdown over the 2018-2021 period (**US$ 4,480,000**) and a maximum amount in 2017 (**US$ 5,600,000**).

Table 3: Budget breakdown by objective

No.	Objective	Amount (in US$)	Proportion of total budget (in %)
1	**Between now and 2021, improve the accessibility of quality of immunisation services, especially for the vulnerable populations in 34 health districts.**	**2,724,223.33**	**11.58**
2	**Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain.**	**10,347,657.02**	**44.00**
3	**Between now and 2021, reinforce involvement by community stakeholders and CSOs in immunisation promotion.**	**1,861,739.32**	**7.92**
4	**Between now and 2021, strengthen the Health Information System and data collection at the national level.**	**2,803,291.59**	**11.92**
5	**Between now and 2021, improve the management and coordination of the programme.**	**5,783,088.74**	**24.59**
	Total	**23,520,000**	**100**

This distribution shows the special importance placed on strengthening the logistics and supply capacities. Indeed, substantial increase of cold chain equipment will be made through the purchase of a large stock of solar refrigerators, vehicles and other related tools, amounting to a total of **US$ 10,347,657.02**, or a bit more than **40%** of the overall budget. With this regard, the detailed Procurement Plan for the acquisition of goods, works and consultant services covering the first two years of programme implementation is attached.

Likewise, the performance based funding will receive nearly **12.8%** of the total budget, representing an envelope of **US$ 3,012,109.14**, which will be used essentially to pay the allowances linked to the quantitative indicators adopted for immunisation.

Generally speaking, the unit costs have been extracted from State reference documents ('*Mercuriale*' public procurement list) and development partners (WHO and UNICEF), or estimated analogically (comparison with activities already carried out and whose costs are known).

With regard the fiscal costs tied to the above-mentioned purchases, the Government will pay for the tax-related costs, customs duties, and the inherent clearing and transport formalities. These costs are evaluated at **US$ 3,152,265**.

The Ministry of Public Health is the foremost implementing authority, with **51%** of the budgeted funds, followed by the development partners and the civil society organisations, with **43%** and **6%** respectively.

2- Financial gap analysis

The analysis of gaps and of complementarity was carried out based on the projection of funding needs for the health sector and the available funding by objective. The estimates were made based on information contained in the

planning documents of the Government and its development partners, in particular:

- The State's 2016-2018 Medium-Term Expenditure Framework;
- The 2015-2019 comprehensive Multi-Year Plan (cMYP) of the Expanded Programme on Immunisation (EPI);
- UNICEF's 2015-2017 Rolling Work Plan;
- WHO's 2015-2017 CVI Programme;
- and the 2016-2020 Health Sector Support Investment Project (PAISS) supported by the World Bank.

To summarise, the gaps analysis can be summed up as follows:

Table 4: Summary analysis of gaps

Objectives of the HSS proposal	Resource requirements	Total Financing	Financing gap	Gavi HSS	% of the gap reabsorbed by the HSS
1. Between now and 2021, improve the accessibility of quality immunisation services, especially for the vulnerable populations in 34 health districts.	**8,850,670**	**5,181,583**	**3,669,087**	**2,724,223**	**80.36%**
2. Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain.	**9,379,169**	**338,092**	**9,041,077**	**10,347,657**	**111%**
3. Between now and 2021, reinforce the capacities of community stakeholders and CSOs in immunisation promotion.	**4,776,433**	**1,125,000**	**3,651,433**	**1,861,739**	**51%**
4. Between now and 2021, strengthen the Health Information System and data collection.	**6,503,151**	**4,198,817**	**2,304,334**	**2,803,292**	**122%**
5. Between now and 2021, improve the management and coordination of the programme.	**12,227,341**	**241,242**	**11,986,099**	**5,783,088**	**55%**
Total	**41,736,764**	**11,084,733**	**30,652,031**	**23,520,000**	**80%**

Generally speaking, it emerges that the resource needs relative to Cameroon's 2017-2021 HSS proposal to Gavi amount to **US$ 41,736,764** and that the Health Sector (State and its technical and financial partners) is capable of mobilising **US$ 11,084,733** or **26.5%**. With Gavi support, the coverage rate of the gap will rise to **80%**, leaving **US$ 7,132,031** to be found.

However, there are significant gaps when we consider each of the objectives.

- **Objective 1: Increase accessibility to health services including quality immunisation, especially in the 21 [sic] priority health districts**

To meet this objective, Cameroon, in a synergy between the Government and its technical and financial partners, will ensure the implementation of activities with contributions of US$ 1,493,500 by the State, US$ 2,546,083 by WHO and US$ 1,142,000 by UNICEF Some activities present 'surplus funding' if we take into account the HSS support from Gavi. For the activity '*Support the development of microplans for the health facilities in 34 targeted HDs*' this comes from the underestimate of the unit cost of the training workshops and of the development and consolidation of microplans of the health districts during the cMYP costing (about US$ 30) compared to nearly US$ 96 when the HSS budget was made (taking into account the fees practiced by the UN agencies). As for the '*Support the*

implementation of at least 60% of the integrated formative supervisions planned by the 34 targeted districts for their health areas' objective, the monthly supervisions by the health districts for their areas were planned (10 per year) even though they are not truly funded by the Sector.

- **<u>Objective 2</u>: Between now and 2021, strengthen the logistical and performance capacities of the EPI's supply chain.**

For this objective, the resources provided by the State are modest, at US$ 338,092 (for the maintenance of equipment and vehicles) compared to the needs amounting to US$ 9,379,169 (only 3.6%). For this purpose, Cameroon is considering devoting the majority of the allocation to sustained increase in cold chain equipment and vehicles, and in their maintenance. This option, which also takes into account the anticipated withdrawal of Gavi funding, will enable Cameroon to have healthy logistics assets during the initial years of vaccine independence, and to better prepare the country to take on this responsibility.

- **<u>Objective 3</u>: Improve quality and use of health information and of monitoring-evaluation for better strategic planning of the sector**

To meet this objective, the State plans to mobilise US$ 625,000 during the Programme period, for the production of communication materials devoted to awareness-raising about routine immunisation. As for the main partner in this area, which is UNICEF, its contribution amounts to US$ 500,000 to '*establish the partnerships between the health facilities and the CBOs, LAs or other community groups in the 34 targeted health districts*' and to '*reinforce the capacities of the stakeholders in charge of communication and of the service providers for immunisation promotion in the 34 targeted HDs*'. With regard to the signing of partnership contracts with the civil society organisations, the HSS Programme support will make it possible to pay for needs that are not expressed but that will have to be met. This explains the coverage of 114%.

- **<u>Objective 4</u>: Increasing the State's contribution to the funding of health actions, including immunisation.**

The overall needs to cover the activities amount to US$ 6,503,151 for the 2017-2021 period; the financing expected from the State is estimated at US$ 2,519,290.00.

There is a funding gap of US$ 2,304,334 that is totally covered by the HSS programme and that will take into account even the activities not originally identified in the Sector (122% overall coverage for the objective). These are mainly '*support for the implementation of activities ensuing from the data quality evaluation*' and '*the carrying out of surveys and evaluations of the health sector, with emphasis on the immunisation system*'.

- **<u>Objective 5</u>: Improve existing management mechanisms so as to implement an efficient and effective Programme**

To reinforce the Programme's management and coordination mechanisms, the overall needs are estimated at US$ 12,227,341. The accumulated contribution of WHO and UNICEF is estimated at US$ 125,000 and that of the World Bank at US$ 1,370,000 for the purchase of the EPI indicators (Penta3 and MCV) as part of the Results-based Financing Programme in 80 health districts. In the proposal, Gavi's contribution is US$ 5,783,088 over the 2017-2021 period and with a gap of US$ 11,986,099. It will make it possible to more regularly hold the coordination meetings at the regional level and health district level, as well as the training of a pool of experts in public finance management to guide the vaccine independence process.

***Pooled fund** applicants are <u>not</u> required to complete the workplan, budget and gap analysis template. Instead, specific information on the sector wide annual workplan and budget should be provided.*

18. Sustainability (*Maximum 2 pages*)

Describe how the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion.

1. Structural sustainability

The political choice consists in maximising the major structural investments of the EPI starting now. For this purpose the 2016-2027 SHS recommends progressive strengthening of the pillars of the health system and the improvement of governance in the sector's programmes and structures as major prerequisites for reaching the projected outcomes in these programmes and structures.

The crucial issue of human resources has begun to be truly taken into account in the health system, through the definition and start of experimentation with various strategies of motivation, incentive and more equal distribution. These changes, to which the technical and financial partners are greatly contributing, are also reflected in the new programmes recently negotiated or in the process of being negotiated. For example, the Global Fund is going to

devote significant resources to improve the aspects of monitoring and community mobilisation for dealing with malaria. With the prospect of integration and complementary of funding, these investments are going to benefit the health system, and by ricochet the EPI.

With regard to financial and accounting management, as of this writing 22 financial management employees (12 accountants and 10 clerks) are going to expand the pool of financial personnel.

As for the institutional framework, the fresh outbreaks of epidemics linked to vaccine-preventable diseases and the non-achievement of programme objectives justify the continuation of the EPI as the institutional authority for immunisation and prevention of the most deadly childhood diseases.

2. Organisational sustainability

The sectoral strategy will be widely disseminated, and the health structures at all levels of the health pyramid will have an annual work plan derived from this strategy that has identified this programme as a major strategic sub-theme. The multi-sector annual work plans represent an opportunity for better taking into account both the priorities of the sector and a sustainable implementation of the programme's actions. Technical and financial support to the health facilities will be provided annually for the development of M&E frameworks of their AWP and the dissemination of their performances report. The mechanisms of valorising the performances made by the service providers at all levels will be clearly defined, shared and implemented (RBF).

3. Socio-cultural sustainability

In accordance with the orientation of the 2016-2027 SHS, Primary Health Care is the strategy advocated to meet the health needs of the population. The principles adopted to implement this are: strengthened community participation, more effective inter-sectoral action, availability of appropriate technologies, and equity and social justice. Efforts will be made to give communities an effective sense of responsibility, so that they become more involved in the management of their health problems.

Decentralisation is a strategic option that provides the possibility to carry out public policies that touch local communities. The following actions will be carried out: (i) capacity building and transfer of community health skills both to the decentralised local communities (DLCs) and to the local populations; (ii) strengthening of the process of formalising contracts with community-based organisations; and (iii) improvement in the technical guidance for DLCs and for community organisations.

The community stakeholders (CSOs, CSO platforms, dialogue structures, associations, etc.) will be made sensitive to the problem of child mortality and will receive guidance in the mother-child interventions.

4. Technological sustainability

Vaccine and input conservation equipment is to be replaced with new renewable energy technology. A maintenance plan for this new equipment will be developed, implemented, monitored and evaluated, in view of its importance in guaranteeing the quality of vaccines and of effective immunisation coverage. A new, large storage facility with capacity of approximately 400m^3 for vaccines and inputs is currently under construction at the central level.

5. Financial sustainability

The State, which is the guarantor of the health of the population and especially of the most vulnerable population, will set up mechanisms to make sure that programme funding continues when Cameroon graduates from eligibility for Gavi funds by 2020.

Two main factors make it possible to organise and ensure the sustainability of ISS and HSS funding. These are to ensure good interconnections and perfect complementarity between the external and internal financial efforts, such as planned in the Sector's strategic documents (SHS, cMYP, NHSP). Furthermore, in view of the gradual decrease in financial contribution by the partners in the coming years, the 2016-2027 SHS mentions the process now underway to set up a health support fund. One of the windows of this fund concerns immunisation, in the form of a law, which when passed and promulgated will have to be respected by all stakeholders. Such an approach is likely to guarantee the sustainable availability of funding. Furthermore, as a major preliminary step to ensure vaccine independence, it is suggested that the State increase its contributions and carefully prepare for the time when it will be nearly totally responsible for vaccine financing.

The Government and its technical and financial partners have started up convergent actions to better target the bottlenecks of the health sector. These efforts are leading to the setting up of some reforms that are likely to remove those bottlenecks. Following the reform of the State financial system, which, in accordance with the SHS orientations, approved replacement of the resources-based budget (FR: *budget des moyens*) by the Budget Programme, resources are expected to be aligned with the priority actions (infant-child mortality).

***Pooled fund** applicants are required to provide existing documentation that addresses sustainability. List which documents have been provided and reference the relevant sections.*

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

19. Implementation arrangements (*Maximum 2 pages*)

Describe the planned implementation arrangements

The programme described in the Gavi HSS proposal will be implemented according to the following principles and arrangements:

1- Governance authorities and arrangements

The implementation of this programme will not lead to the creation of ad hoc bodies that are parallel to existing bodies. However, modifications to the institutional framework of the Sectoral Health Strategy have been provided for, as soon as the new 2016-2027 SHS starts to be implemented. The Sectoral Health Strategy Steering Committee (SHS-SC), which will become the body for management, strategic orientation and decision-making for all the MOH programmes, will be expanded to the members of all the existing committees (ICC, PLMI, CNLS [national council for AIDS prevention], CCM, etc.) and will take care of management of the Gavi HSS programme. The ICC will then become a sub-committee of the SHS-SC. Its role will be to see to it that the activities follow the objectives pursued by the MOH and Gavi, and to supervise the overall execution of the Programme.

The technical aspects of the Gavi HSS programme (technical and financial planning, M&E, control and audits) will be prepared by the EPI permanent secretariat and sent for amendments and enrichment to the SHS-SC Technical Secretariat expanded to the ICC and other sub-committees, which will submit them to the SHS-SC. The latter will meet in ordinary sessions every three months for steering of the sector, or in extraordinary sessions if necessary.

The SHS-SC Technical Secretariat will be specifically in charge of approving the annual activity and financial reports, validating the Annual Work Plan and its related budget, evaluating the state of programme implementation, making appropriate recommendations along with ensuring their M&E, and seeing to it that the Programme's management authority works properly. It will also be in charge of working out the agenda of steering committee meetings and of following the recommendations made. It will prepare the technical files for these meetings and will write the reports.

The Development Cooperation Division will continue to play an interface role between the MOH and its technical and financial partners.

The control and audits will be carried out both within the programme by experts assigned to this effect and via occasional operations by the MOH General Inspection Division at the central level, the inspection teams (FR: *Brigades de Contrôle*) at the regional level and the annual external audits.

2- Proposal's authorities and arrangements for coordination and management

The principal responsible body for management of the proposal at the legal, technical and institutional level is Cameroon, through the Ministry of Public Health (MOH).

However, the coordination and management of the project will be taken care of by the TAG-EPI. There are plans to create a Programme coordination team, which will be formalised after the organisational audit of the TAG-EPI commissioned by Gavi, which will take place in March 2016. Through this team, the TAG-EPI will thus be responsible for (i) detailed development of activities or operational planning; (ii) the coordination of activities, including ensuring the availability of resources needed for activity implementation; (iii) information from the various authorities of the Programme, in particular the SHS-SC and those of technical and administrative execution; (iv) control and monitoring of the administrative and technical execution; (v) updating of the projected programmes and budgets; (vi) bookkeeping and the establishment of periodic reports on the technical and financial execution; and (vii) management of interface with all stakeholders.

3- Main implementing authorities and their responsibilities

Because of the strong concentration and the alignment of the Programme's activities with those of the EPI, the latter will take care of implementation, under the responsibility of its Permanent Secretary and with the technical and financial support of the PTFs.

However, implementation of community activities will be taken care of by the CSOs, which will work in close cooperation at the regional level with the FRPS and the dialogue structures (COSADI) at the HD level. These NGOs belong to a platform that has been working together with the EPI since 2014 as part of the Gavi HSS programme that is currently being implemented. This cooperation is based on a three-party Memorandum of Understanding signed on 1 October 2014 with the Ministry of Health and WHO.

The technical and financial partners of the MOH, especially the statutory partners of the Gavi Alliance (WHO and UNICEF) as well as others such as AMP will join in the implementation operations, each according to what they are authorised to do. The detailed terms of collaboration and partnership within this framework will be specified in a Memorandum of Understanding.

The main responsibilities that will be entrusted to the implementing partners and agencies include: i) quality assurance of operations and technical exercises; ii) capacity building; iii) perfecting technical tools in accordance with international standards; iv) the sharing of international experiences likely to lead to improvement of skills and national practices; and v) purchase assistance for equipment.

4. The role of the development partners in implementation of the Programme

In addition to support for the execution of activities as mentioned above, the development partners will have the following roles: (i) contribute to advocacy for better visibility internationally of Cameroon's efforts in Health System Strengthening; (ii) facilitate the mobilisation of additional external resources for the health sector; and (iii) provide support so that technical assistance can be available.

5. Technical assistance needs

Cameroon will need multiform national and international assistance for implementation of the Programme, especially in the area of vaccine supply chain and logistical management, in strengthening the SNIS and in improving data quality and the various coverage evaluations and surveys to be carried out as part of M&E. This will make it possible to reinforce local capacities, as well as to give, in certain cases, an independent character to the evaluations. Its sustainability will be ensured by a work mechanism of two-person teams. In this mechanism, each technical assistant will work in close cooperation or be assisted by one or two local experts for skill-transfer needs.

Technical assistance will be needed for the following interventions:

- The EVM Assessment;
- Training logisticians and maintenance workers;
- Installation and maintenance of the cold rooms;
- Training in the DHIS2;
- Incorporating the DVD-MT, SMT and LMIS into the DHIS2;
- The EPI external evaluation;
- The coverage survey;
- The independent evaluations of data quality [TRANSLATOR'S NOTE: *lacuna in text re. type of data]*;
- The SARA surveys;
- The revision of the 2016-2019 cMYP.

The technical assistance plan of the present proposal is attached.

6. Overall budget allocated to management of the proposal

The budget allocated to management of the Programme is **US$ 2,713,161**, or **11.54%** of the total grant. It covers the expenses linked to EPI planning, the final evaluation of the Gavi HSS Programme, to the coordination meetings in the Regions and health districts, to the integrated formative supervisions by the central level towards the Regions and to the operating costs of the Programme's management team.

For this last component in particular, a marginal share (4%) of the HSS resources will be allocated to the everyday operating costs of the implementing organisations (EPI, CSOs, CIS, DCOOP, SHS-SC TS). These costs will mainly include the fixed operating expenditures and the allowances for the extra and special work done by the personnel involved in the implementation, this in accordance with the stipulations of the decrees No. 66/DF/111 of 11 March1966 and No 74/694 of 29 July 1974 and their subsequent modifications.

Pooled fund *applicants are required to provide documentation of the implementation arrangements of the sector wide mechanism, if appropriate. List which documents have been provided and reference the relevant sections.*

20. Involvement of Civil Society Organisations (CSOs) (*Maximum 2 pages*)

Describe how CSOs will be involved in the implementation of the HSS grant.

Cameroon adopted the policy of reorientation of primary health care in 1993, following the Bamako Initiative. This policy is characterised by development of 'dialogue structures'. To date, the community action has consisted in:

- participation of local populations in financing health services;
- participation by community representatives in co-management;
- actions involving advocacy, communication and social mobilisation by civil society organisations;
- the services of community health workers;
- the community initiatives for promotion of health.

With regard to civil society, around 160 NGOs and associations participate formally in the activities of the Ministry of Public Health (via cooperation agreement letters, framework agreements and implementation contracts). This approach is in line with the 2035 Cameroon Outlook, which considers civil society organisations as strategic partners of the State, in that they represent a melting pot of participation and social mobilisation for integrating productive forces and democratisation within a context of decentralisation.

Strong involvement by all the community stakeholders through communication and community mobilisation was identified as one of the important themes of the 2014-2020 EPI strategic communication plan. Along with support from several TFPs, other experiences have helped reinforce community demand, via the training of the Focal Points in interpersonal communication at all levels (30 central supervisors, 10 CFPs from the Regions, 189 CFPs from the districts, 4997 CFPs from the health areas and 15,866 social mobilisers. Other initiatives have also helped strengthen demand for immunisation, through i) the deployment of networks of women mayors, clergy, resellers ('bayam-salam'); ii) the trade union of urban and inter-urban transporters; iii) advocacy via the governors' forums; and iv) the signing of a partnership framework between the Ministry of Public Health, the Minister for the Promotion of Women and Families and UNICEF.

Community participation in the 2017-2021 Gavi HSS project will be under the responsibility of the CSO partners of the MOH.

As part of the 2017-2021 Gavi HSS proposal, the main objective of the multi-sectoral community response will make it possible to strengthen the equitable use of immunisation services, especially by the vulnerable populations in the 34 targeted HDs between now and 2021. In terms of approaches likely to guarantee the results, Cameroon has opted – based on previous experiences – for the capitalisation of available local human resources, by insisting on the process of integrating all the communication stakeholders at all levels. Furthermore, special emphasis will be placed on the coordination of activities with all the other partners working at the community level (dialogue structures, health workers, traditional healers, networks of women mayors, women's associations). Community teams (FR: *brigades*) will be developed in all the targeted health districts in order to promote routine immunisation and look actively for those lost to follow-up, the AFP and the other diseases with epidemic potential. The dialogue structures will be strengthened so that they can better fulfil their roles.

The CSOs will provide technical support to formalising contracts with the LAs or other community groups, via their dialogue structures. The main activities decided on consist in i) carrying out the microplans of the targeted health facilities (health areas and health districts); ii) implementing the immunisation sessions part of outreach and mobile strategies (or of another suitable strategy for reaching each community) that are planned in the targeted health districts; and iv) improving the quality of supply and demand of integrated services within health facilities via PBF in the targeted districts and M&E of communication activities.

A total amount of US$ 1,861,739 (or 7.92% of the Gavi HSS grant) will be allocated to carrying out the community activities coordinated by PROVARESSC, in accordance with the administrative stipulations provided for in the budget framework of this request. The funds made available to the Ministry of Public Health by Gavi via the *Caisse Autonome d'Amortissement* (Cameroon's public debt redemption fund) will be transferred to the CSOs according the financial management procedures in force. These CSOs will organise and coordinate implementation of the activities of the CBOs and the dialogue structures of the health areas (COSAs). Each level of intervention will take into account and justify all the funds made available to it.

***Pooled fund** applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.*

21. Risks and mitigation measures (*Maximum 2 pages*)

If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised 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: Between now and 2021, improve the accessibility and the quality of integrated immunisation services, especially for the vulnerable populations in 64 [sic] health districts.			
Institutional Risks The quantitative lack and low level of motivation of human resources	Medium	High	i) Formalising contracts with personnel at the operational level; ii) Aligning the grant with the Results-based Financing Programme.
Fiduciary Risks: Non-respect of the administrative and financial management procedures	Medium	High	i) Distribution of the manual of procedures, and capacity building for its use; ii) Regularity of internal and external audits and applying the ensuing sanctions.
Overall Risk Rating for Objective 1	**Medium**	**High**	
Objective 2: **Objective 2: Between now and 2021, strengthen the EPI's logistical capacities and EPI equipment.**			
Institutional Risks: Complex public procurement procedures	Medium	Medium	i) Development of a public procurement plan to anticipate the public procurement stages; ii) use of the purchase assistance system of the United Nations.
Operational Risks Weak level of functionality of the maintenance system of the equipment and materials purchased	Medium	Medium	i) Implement the plan for outsourcing maintenance; ii) define and see to the application of incentive measures and sanctions linked to the use of the equipment and material purchased; iii) make expertise and skills available to the TAG-EPI in the field of logistics and maintenance of vehicles and cold chain and biomedical equipment.
Overall Risk Rating for Objective 2	**Medium**	**Medium**	
Objective 3: Between now and 2021, reinforce involvement by community stakeholders in immunisation promotion and other child health interventions.			
Institutional Risks	Medium	Medium	Validation of the platform's manual of procedures by the MOH.
Operational Risks	Medium	Medium	Mapping of the community stakeholders involved Formalising contracts with the CBOs/LAs/COSADIs

Overall Risk Rating for Objective 3	***Medium***	***Medium***	
Objective 4: Between now and 2021, strengthen the system of immunisation data collection, analysis and use, for decision-making.			
Institutional Risks *Lack of qualified and motivated personnel for data management at the operational and intermediary level.*	Low	Low	Training of personnel available to round out the offer of qualified personnel
Operational Risks *Weak level of functionality of the maintenance system of the computer equipment and materials purchased*	Low	Low	i) Implement the maintenance outsourcing plan; ii) define and see to the application of incentive measures and sanctions linked to the use of equipment and material purchased.
Overall Risk Rating for Objective 4	**Low**	**Low**	
Objective 5: Between now and 2021, improve the performance of the Gavi HSS Programme by strengthening the governance and management of the EPI.			
Fiduciary Risks *Gaps in the programme management*	Low	Low	i) Distribution of the manual of procedures, and capacity building for its use; ii) Capacity building in project management for managers; iii) Regularity of internal and external audits and applying the ensuing sanctions.
Overall Risk Rating for Objective 5	**Low**	**Low**	
(Add more rows for additional objectives as required)			
Pooled fund *applicants are required to provide any risk mitigation plan under the sector wide/ pooled funding mechanism.*			

22. Financial management and procurement arrangements

Describe the proposed budgetary and financial management mechanisms for the grant.

1. Budget management

Under the aegis of the SHS-SC Technical Secretariat, the implementing bodies identified by a work group will draw up, at the beginning of the period, a Budget Orientation Memo and Annual Budgeted Work Plan for the Gavi HSS Programme.

These strategic documents will be put to formal approval by the SHS-SC during one of its ordinary or extraordinary sessions.

2. Financial management

The rules of financial management of the Gavi HSS programme are defined in the EPI manual of administrative, financial and accounting procedures.

In brief, the Gavi HSS Programme funds will be transferred beforehand to a bank account opened at a commercial bank by the *Caisse Autonome d'Amortissement -CAA-* (Cameroon's public debt redemption and external financing fund). These funds will then be transferred to another account opened by the CAA on behalf of the EPI. From there, the funds will be made available to each implementing authority by bank transfer, after validation by the MOH of the draft transfer orders sent by the EPI.

The HSS Programme accounting in each implementing authority will be done with the help of the financial and accounting management software TOMPRO, version TOM 2 PRO (web). This will replace the Windows 5.9.2 mono-project and multi-site version obtained by the EPI in 2012. Training of the people in charge of this accounting will be carried out before the switch in accounting software.

Financial reports will be produced quarterly by each implementing authority (except WHO and UNICEF) and consolidated by the project team. They will be put to validation by the SHS-SC at the end of each quarter, at the same time as the activities report.

The internal audit will be implemented according to three main arrangements:

- The integrated formative supervisions, which will make it possible to evaluate whether the management practices conform with the stipulations of the EPI's administrative, financial and accounting procedures.
- The missions for controlling the management of funds received; these will lead to periodic identification of the debtors and to application of corrective measures.
- Examination and validation of the annual financial statements of the beneficiaries bodies, at a workshop for accountability reporting.

As for the external audit, it will be conducted by a specialised independent firm after selection according to the terms in force. Furthermore the Government has an office for verifying the use of funds made available to State or State-subsidised bodies (Supreme State Audit Office [FR: *Ministère* [sic] *du Contrôle Supérieur de l'Etat*]). This office reserves the right to carry out periodic audits.

For procurement, legislation and national regulations will be applied, except in the case of certain derogations defined as part of an agreement between Gavi and Cameroon. It should be noted that, while the public procurement code shall be the legal reference document for markets of a certain scale (more than FCFA 5 million), the administrative order form procedure will be adjusted in order to reduce administrative red tape, which is a factor that limits the swift implementing of several activities of the Programme.

Some specific procurement will be carried out by Gavi partners such as WHO and UNICEF when it appears there are undeniable advantages in doing so compared to other conventional channels (State, CSO, etc.). A Memorandum of Understanding exists since 2009 between the MOH and UNICEF concerning procurement of vaccines and related supplies, in the framework of Gavi support for new and underused vaccines. This memorandum will be revised in order to expand UNICEF's field of action to other types of procurement related to the Gavi HSS Programme. A similar agreement will be signed with WHO and other partners if need be.

Describe the main constraints in the health sector's budgetary and financial management system.

- There are programme-related divergences from the TFPs that lead to weak convergence and coordination of Health Sector funding for reaching the latter's priority objectives.
- The absence of harmonisation of the multiple forms of managing external funding causes inefficiency in the operational processes of budgetary and financial management.
- Insufficiency in human resources in terms of quantity and quality leads to a shortage of qualified accounting and

financial personnel. The qualified managers are divided up among the various health programmes of the MOH and do not benefit regularly from capacity building.

The Government will put special emphasis on continuing education for this personnel in the field of financial management, accounting, the tax system and auditing.

Complete the Budgetary and Financial Management Arrangements Data Sheet (below) for each organisation that will directly receive HSS grant finance from Gavi.

*Provide **Mandatory Attachment #7**: Detailed two-year Procurement Plan*

***Pooled fund** applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement.*

Budgetary and Financial Management Arrangements Data Sheet

Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).

1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	**Name:** ANDEGUE Luc Florent **Title:** Director of Financial Resources and Assets of the Ministry of Public Health **Contact details:**<lucandegueflo@yahoo.fr> **Tel:** +237 699 98 00 93/ +237 679 87 41 49/ +237 222 22 57 83
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	The situation of the support received from the development partners can be presented in the table below: **Name of partner** / **Grant amount (in FCFA million)** / **Year** WHO — 6000 — 2014-2015 UNFPA — 3000 — TBD UNICEF — 5500 — TBD BID — 13,500 — TBD World Bank — 32,500 — TBD BADEA — 2,327 — TBD Joint programme (AFD & KfW) — 37,717.53 — TBD Gavi — 23,000 — 2010-2011 For the terminated grants from the development partners, the regularly produced financial execution reports – in particular for reviews – have generally indicated satisfactory rates of achievement of activities and of financial execution. With regard the terminated grants from Gavi, management dysfunctions had been noted in the budgetary and financial execution of the first HSS grant. Cameroon has proceeded to reimburse the disputed funds and has

	committed itself to normalising its relations with Gavi by signing a Partnership Framework Agreement that decrees the fundamental principles of financial management. *(Attachment 2- Section C: Management and use of Gavi funds and supplies, and Attachment 3 Transparency and Financial Responsibility Policy).* On the operational level, an EPI manual of administrative, financial and accounting procedures has been produced for the stakeholders involved in management. For the Gavi grants underway, the evaluation of the 2014-2016 transitory HSS Programme has revealed the following main conclusions: ▪ There is better coordination and planning of activities, with strengthening of accountability and the accounting system, in particular following the one-off decision to entrust the management of the HSS funds to WHO until the MOH's management system is restructured. ▪ Greater coherency has been validated, from expenditure to budget planning, although with high management costs that affect the efficiency of the Programme. ▪ Cameroon is currently implementing corrective actions for the reliability of the financial system and national accounting, this through the setting up of stricter management rules via the production of a manual of administrative, financial and accounting procedures.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Oversight of the Gavi HSS Programme will be provided by the Sectoral Health Strategy Steering Committee, chaired by the Minister of Public Health. This committee will be expanded to the members of all the existing committees (ICC, PLMI, CNLS [national council for AIDS prevention], CCM, etc.). All these sub-committees at the regional level will be dissolved, and a bill creating the equivalent of the SHS-SC will be worked out. The Steering Committee will meet in ordinary session quarterly and in extraordinary session when convened by its Chair.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	Under the aegis of the SHS-SC Technical Secretariat, the implementing bodies identified by a work group will draw up, at the beginning of the period, the work plan and annual budget of the Gavi HSS Programme.
6. What is the planning & budgeting process and who has the responsibility to approve the Gavi HSS annual work plan and budget?	A multi-disciplinary and multi-sectoral working group that was proposed by and will be coordinated by the SHS-SC Technical Secretariat will be set up to work out, in a participative and dynamic way, the Gavi HSS work plan and annual budget. These latter are to be approved by the SHS-SC. The major calendar events of this working group will be: ➢ Review of the annual performances of the Gavi HSS Programme and evaluation of the progress made; ➢ Situational analysis with diagnostics of the persistent bottlenecks and the risks; ➢ Revision of implementation strategies, if need be;

<table>
<tr><td></td><td>➢ Identification of the priority activities to carry out;

The work plan and annual budget of the Gavi HSS Programme will be subject to official validation by the SHS-SC during one of its ordinary or extraordinary sessions.</td></tr>
<tr><td>7. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?</td><td>YES. Cameroon's Law of Finance authorises, each year, the taking into account of external funding in the State Budget. The MOH budget includes an item dedicated to these contributions.</td></tr>
<tr><td colspan="2">Budget Execution (incl. treasury management and funds flow)</td></tr>
<tr><td>8. What is the suggested banking arrangement? (i.e., currency of the account, fund movements to the programme). Please list the titles of the signatories authorised to carry out payments and requests for resupplying of funds.</td><td>- Currency of the account XAF (FCFA)
- The flow of funds towards the programme depends on the activity timeline validated by the SHS-SC.
- List of titles of signatories authorised for release of funds:
<table>
<tr><th>Name of authority:</th><th>Title</th><th>Phone</th></tr>
<tr><td>Mr André MAMA FOUDA</td><td>Public Health Minister</td><td>+237 222 220 172</td></tr>
<tr><td>Mr Dieudonné EVOU MEKOU</td><td>Director-General of the Caisse Autonome d'Amortissement</td><td>+237 222 222 226
+237 222 239 948
+237 222 220 187</td></tr>
<tr><td>Dr Marie KOBELA</td><td>Permanent Secretary of the TAG-EPI</td><td>+237 699 56 74 25</td></tr>
</table></td></tr>
<tr><td>9. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank, or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?</td><td>The Gavi HSS Programme funds will be transferred beforehand to a bank account opened by the Caisse Autonome d'Amortissement -CAA- (Cameroon's public debt redemption and external financing fund) at a commercial bank on behalf of the EPI.

Then, gradual transfers will be sent from this account to the bank accounts of each implementing authority.</td></tr>
<tr><td>10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- “pooled account”)?</td><td>The CAA-Gavi-HSS (or MOH-Gavi-HSS) bank account will be fuelled only with the Gavi funds released for the implementation of the HSS Programme.</td></tr>
<tr><td>11. Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.</td><td>YES. In accordance with the level of the health pyramid at which the planned activities will be implemented, the transfer of funds towards the sub-national levels will be carried out from the account managed by the Caisse Autonome d'Amortissement (or by the MOH). This transfer will be in accordance with the MOH’s order for provision prepared for the EPI in favour of each implementing authority, based on the validated action plans and budget.

Each implementing authority will in turn perform bank transfers to its beneficiary bodies.

Reception of funds at the national level and the prompt provision of these funds to the sub-national levels is to be the first month of the year (January).</td></tr>
<tr><td colspan="2">Procurement</td></tr>
<tr><td>12. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other</td><td>For the governmental implementing authorities, the national legislation on public procurement will be the legal system of</td></tr>
</table>

Development Partners' procurement procedures)	reference for procurement based on Gavi HSS funding. Simplified procedures will be defined in the manual of procedures for purchases costing less than FCFA 5 million. For the non-governmental implementing authorities, public procurement will be carried out in accordance with their duly validated manuals of procedures.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Some specific procurement will be carried out by Gavi partners such as WHO and UNICEF when it appears there exist undeniable advantages in doing so compared to other conventional channels (State, CSO, etc.).
14. What is the staffing arrangement of the organisation in procurement?	A Memorandum of Understanding exists since 2009 between the MOH and UNICEF concerning procurement of vaccines and related supplies, in the framework of Gavi support for new and underused vaccines. This memorandum will be revised in order to expand UNICEF's field of action to other types of procurement related to the Gavi HSS Programme. A similar agreement will be signed with WHO and other partners if need be.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES. The Cameroonian institutional system includes services in charge of physical inspection of the work. Internally, the personnel in charge of materials accounting appointed to each body will ensure, on a continual basis and in accordance with the rules set out by the national regulations in force, the monitoring and control of supplies, by guaranteeing that such supply and services effectively took place. Externally, controls of budget execution and of materials accounts are regularly performed by the competent services of the Minister of Finance. Furthermore, the EPI manual of administrative, financial and accounting procedures gives a reminder of and clarifies the management rules and procedures pertaining to it.
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES. Cameroonian legislation and regulations provide for two main mechanisms for lodging complaints: - Administrative recourse (with the Minister in charge of public procurement, the contracting authority, or the Public Contracts Regulatory Agency for sanction of procedures); - Legal recourse, by submitting the complaint to the administrative court.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES. Most of the measures concerning the management of disagreements are included in the procurement models (contracts). The administrative courts apply the rules and procedures defined by the administrative law applicable to the public procurement litigation.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	The accounting procedures of the partner concerned by the agreement apply when the procurement is carried out through its channel.
19. What procurement system will be used for the Gavi HSS Programme? (Is there a specific accounting software or a manual accounting system?)	The system of accounting procedures for the Gavi HSS programme are described in the EPI manual of

	administrative, financial and accounting procedures. The HSS Programme accounting itself will be done with the help of the financial and accounting management software TOMPRO, version TOM 2 PRO (web). This will replace the 5.9.2 mono-project and multi-site version obtained by the EPI in 2012. Training of the managers concerned will be carried out before the switch in accounting software.
20. How often does the implementing entity produce interim financial reports and to whom are they submitted?	The intermediary financial reports are produced quarterly by each implementing authority and consolidated at the TAG-EPI level. They will be put to validation by the SHS-SC at the end of each quarter, at the same time as the activities report.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES.
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES. The MOH has an internal General Inspectorate of Administrative Services (*IGSA*) in charge of internal administrative and financial audits. The *IGSA* takes care of coordinating and leading internal audit activities that will be implemented by a joint team. This latter is appointed by the Minister of Public Health based on a proposal by the SHS-SC Technical Secretariat; it is made up of financial experts and accountants from the implementing authorities, in accordance with a plan validated beforehand.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES. The ICC regularly ensures the monitoring of implementation of internal audit recommendations. These are implemented by the technical ICC, under the technical coordination of the internal auditor of the Technical Advisory Group of the EPI.
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[4]	Yes. By a specialised firm selected according to the terms in force. Furthermore the Government has an office for verifying the use of funds made available to State or State-subsidised bodies (Supreme State Audit Office [FR: *Ministère* [sic] *du Contrôle Supérieur de l'Etat*]). This office reserves the right to carry out periodic audits.
25. Who is responsible for the implementation of audit recommendations?	The TAG-EPI will ensure implementation of the audit recommendations, in close cooperation with the other implementing authorities.

[4] If the annual external audit is planned to be performed by an independent private audit firm, an appropriate audit fee needs to be included in the budget.