



Health Systems Strengthening (HSS) Cash Support

Application Package – Proposal Form

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

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

HSS Proposal Forms and Mandatory GAVI attachments		
<i>→ Please place an 'X' in the box when the attachment is included</i>		
<i>No.</i>	<i>Attachment</i>	<i>X</i>
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and HSCC members	X
3.	HSS Monitoring & Evaluation Framework	X
4.	Detailed work plan and detailed budget	X

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

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

GAVI's Approach to Health System Strengthening

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

- One of GAVI's strategic goals is to “*contribute to strengthening the capacity of integrated health systems to deliver immunization.*” The objective of GAVI-HSS support is to address system bottlenecks to achieve better immunization outcomes, including coverage and equity. As such, it is necessary for the application to be based on a strong analysis of the bottlenecks and gaps and present a clear results chain demonstrating the link between proposed activities and improved immunization outcomes.
- GAVI's approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate outcomes as well as immunization outcomes such as DTP coverage, measles coverage, and % of districts reporting >80% coverage. Therefore the application must include a strong Monitoring & Evaluation framework aligned with the national M&E plan or national M&E processes.
- Results based financing is a core approach of GAVI-HSS support. All applications must align with the new GAVI *results based financing* (RBF) approach: introduced in 2012. Countries' performance will be judged on a predefined set of RBF indicators against which additional payments will be made to reward good performance in improving immunization outcomes.
- GAVI supports the principles of alignment and harmonization (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how GAVI support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in these guidelines.
- GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not required for a GAVI-HSS application. However, if this type of assessment has been carried out, conclusions from it can be included in a country's HSS application. The Independent Review Committee (IRC) will use the results of the JANS assessment to better understand the political context in which the health sector exists; this will inform the Committee as it evaluates the credibility and feasibility of the HSS proposal.
- GAVI recommends that a consultative and participatory approach be used for drafting the HSS proposal, and, particular, that there be cooperation between responsible departments within the Ministry of Health (for example, the planning department, the EPI, health information management systems, the entity in charge of M&E), development partners and civil society. When the HSCC (or its equivalent) is asked to sign the proposal, the ICC (or its equivalent) must also be consulted and brought into the process as the proposal is being finalized.
- GAVI encourages the countries to identify and establish links between HSS support and support for introducing new vaccines (such as GAVI support of new vaccines). These linkages must be demonstrated within the application. Countries will need to demonstrate system readiness¹ for new vaccines to be introduced within the context of routine immunization services. GAVI-HSS support will be for strengthening these routine immunization services and country readiness for the introduction of new vaccines.
- GAVI's approach to HSS includes support for strengthening data systems. Strong data systems are of fundamental importance both to countries and to the GAVI Alliance. Countries are strongly encouraged to include in their proposals actions to strengthen the data system, including the institutionalization of routine mechanisms to track data quality improvements over time.
- GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities to address the HSS bottlenecks to improving immunization outcomes.

¹For a definition of 'systems readiness' see:

http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/.

- GAVI encourages applicants to include funding for Civil Society Organizations (CSOs) in implementation of HSS support to improve immunization outcomes. CSOs can receive GAVI funding through two channels: (i) GAVI sends funds to the Ministry of Health which then transfers them to the CSO, or (ii) GAVI sends funds directly from GAVI to the CSO. Please refer to Annex 4: CSO Guidelines.
- Applications must include details on lessons learned from previous HSS grants from GAVI or support from other sources.
- Applications must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the additionality of GAVI support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources.
- Cash disbursed for HSS support must be used solely to fund HSS Program Activities. These funds may not be used to purchase vaccines or meet GAVI's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

The Application Process

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

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

Figure 1: The Application Process and Implementation



PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

For further instructions, please refer to the Guidelines for Completing the HSS Application

Applicant:	<i>Ministry of Health - Health System Strengthening Platform</i>
Country:	<i>Benin</i>
Proposal title:	<i>Application for Health System Strengthening (HSS)</i>
Proposed start date:	July 2014
Duration of support requested:	Five (5) years July 2014 – December 2018
Total funding requested from GAVI:	US\$ 8.38 million
Contact Details	
Name	Mathias Finoude
Organization and title	Director for Planning and Forecasting at the Ministry of Health
Mailing address	01 BP 840 Cotonou Benin
Telephone	(229) 21 33 49 06/ 95 42 44 92/ 90 10 12 53/ 97 29 11 62
Fax	
E-mail	finoude@yahoofr.com

Signatures: government endorsement

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

Minister of Health

Minister of Finance

Name: **Pr Dorothée Kinde-Gazard**

Name: **Mr Jonas A. Gbian**

Signature:

Signature:

Date:

Date:

HSCC / ICC SIGNATURE PAGE

For submission with GAVI-HSS application

Health Sector Coordination Committee

Country _____ **BENIN**

Date HSS application: Tuesday, September 03, 2013

We, the undersigned members of the HSCC or equivalent committee [1], met in the ordinary session of the Inter-agency Coordinating Committee (ICC) for Immunization to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached.

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

Name of the HSCC in country __HSS CC_____

Health Sector Coordination Committee			
Name/Title	Agency/Organization	Signature	Date

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

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

Part B – EXECUTIVE SUMMARY

The goal of GAVI-HSS support is to contribute to reaching the Millennium Development Goals in Benin, in particular, objectives 4 and 5, by strengthening health system performance by offering equal-access and quality health care.

The implementation of the GAVI-HSS grant is planned for a period of 5 years (July 2014 to December 2018) for a total amount of (outside of PBF) of US\$ 8,374,702, of which US\$ 0.759 million (9%) is to be used for proposal management. Additional GAVI-HSS financing acquired for performance will be used to support the implementation of the Results Based Financing approach (RBF) in the two targeted health zones.

GAVI-HSS support is included within the framework of the 2009-2018 National Health Development Plan (NHDP) and its monitoring and evaluation plan. It is also included within the framework of the Benin Results Based Financing (RBF) strategy, which will support implementation complementary to other partners, specifically the World Bank, *Coopération Technique Belge* (Belgian), Global Fund, the World Health Organization and UNICEF.

GAVI-HSS support addresses removing priority system bottlenecks within the health system that affect the results of immunization in terms of actual coverage and equity:

- Inadequate coverage of quality health services--immunization in particular--as well as the low use of services,
- Weak capacity within the cold chain at the department, commune and operational levels, and vaccine management that needs improvement,
- Weak performance of the health information system and under-utilization of data for monitoring and evaluation and strategic planning.

The GAVI-HSS proposal has the following three objectives:

Objective 1: Increase coverage of quality health and specifically immunization services, and the use of health services within the two health zones targeted for implementation of Results Based Financing (GAVI-HSS support = US\$ 5,759,434 or 69% of the total). In consideration of the amount of funds available, implementation of RBF will only be applied to two health zones (Tchaourou and Sakété-Ifangni) and will be based on both health performance and complementarity with support from other RBF TFPs.

- RBF financing will allow, in addition, to increasing the motivation of health workers to perform, as well as support for immunization activities (purchase of small equipment, motorbikes, support for outreach strategies, etc.). In addition, RBF performance indicators take immunization outcomes into account, as well as quantitative and qualitative results at the health-facility and community liaison level. This is an indicator of improvements in actual immunization coverage and improved equity where immunization is concerned.

Objective 2: Strengthen cold chain capacity at the intermediate level and within the two targeted health zones as well as increase in efficient vaccination management (GAVI-HSS support = US\$ 895.555, 11% of the total)

- This objective addresses removing bottlenecks linked to insufficient cold chain capacity at the department and operational levels so that EPI vaccines are conserved, as well as targeting the weaknesses that exist in vaccine management. This is directly included in the 2012 EVM recommendations, the vaccine management improvement plan, and the 2014-2018 cMYP. It is in addition to support from other TFPs, in particular, the WHO and UNICEF, for strengthening the cold chain and vaccine management.
- The main issue will be to ensure adequate vaccine storage capacity (for current vaccines as well as new vaccines) in two departments (Borgou/Alibori and Ouémé – Plateau), the two targeted RBF health zones and three (3) related communes. Other areas of efficient vaccine management will be reinforced through training, supervision, monitoring and evaluation, logistical support and equipment maintenance. By reinforcing the EPI vaccination supply chain, storage and distribution, we expect there to be improvements in the availability and quality of vaccinations in Benin as well as a decrease in vaccine expiration rates.

Objective 3: Strengthen SNIGS and the use of data for monitoring and evaluation and strategic planning (GAVI-HSS support = US\$ 960,419 which is 11% of the total)

- This objective supports removing bottlenecks linked to weak performance within the national health information and management system and under-utilization of data for M&E and strategic planning. This supports the implementation of the strengthening plan for SNIGS in complementarity with the participation of other TFPs (CTB, World Bank, UNICEF, USAID, WHO)

- It specifically addresses the availability and quality of health data to be used to strengthen the capacity of SNIGS workers, the quality control and validation of these data, as well as carrying out surveys and related studies. Better creation and use of health information will allow for improving the quality of annual EPI sector and program reviews as well as M&E programs. Monitoring and evaluation, decision-making and strategic planning for EPI interventions will also improve as a result and will contribute to improving immunization coverage and the equitable nature of it.

In accordance with the May 2012 Benin-GAVI Aide Memoire, the Health System Strengthening Project - Coordination Unit (HSSP-CU) will be in charge of managing GAVI-HSS support. This Aide-Memoire specifically defines the administrative and financial management modalities of GAVI support at the different levels of health administration. The other main implementing entities identified are: ANV-SSP/MS (activities linked to objective 2); the Ministry of Health's Directorate of Planning and Forecasting - DPF (mainly activities linked to objective 3); the two targeted Health Zones (RBF funds), the office of external audit (Zone Auditors) and the CSO in charge of the second-level auditing of the RBF indicators.

The monitoring and evaluation system for GAVI-HSS support depends on the entities and mechanisms that exist within the Ministry of Health:

- The HSSP-CU will be in charge of developing and monitoring the programmatic and financial implementation of the Annual Work Plans and the developing the semi-annual and annual progress reports that are due to GAVI.
- The Coordination Committee for Health System Strengthening (CC-HSS) will ensure the general direction of the GAVI-HSS proposal and will validate the Annual Work Plans as well as the progress reports.
- The Ministry of Health's Directorate of Planning and Forecasting (DPF) of which SNIGS is a part of, will be in charge of producing the indicator data (intermediate outcomes, outcomes related to immunization and impact) used in the GAVI-HSS monitoring and evaluation plan. To do so, the Ministry of Health's Directorate of Planning and Forecasting will use different systems to collect and analyze SNIGS data and Ministry of Health programs as well as specific survey results.
- The monitoring and evaluation of quantitative and qualitative RBF indicators will be carried out by the HSSP-CU according to the specific modalities defined in the strategic RBF document for Benin. The HSSP-CU will support the (independent) Zone Auditors in auditing indicators and the Community-Based organizations under contract to provide a second-level indicator audit.

In addition to the 6 outcome indicators for the required GAVI immunizations, 8 intermediate outcome indicators have been established:

Objectives	Intermediate outcome indicators
1	Disbursement Rate of RBF funds in the two health zones
1	Disbursement rate for RBF funds for community liaisons in the two health zones
1	Yearly average rating earned by the two health zones for the qualifying RBF criteria for area 8 (immunization and monitoring of infants and children under 5)
2	Success rate for storage capacity needs at the intermediate level for all immunizations
2	Proportion of evaluation criteria for efficient immunization management with values greater or equal to 75% (national and intermediate levels and health centers)
2	Rate of vaccine stock shortage
3	Completeness rate for vaccination data
3	Report data consistency index (4 value indicators weighted)

Civil Society Organizations (CSOs) will participate in HSS Coordination Committee decisions. With regard to the implementation of RBF in the two targeted health zones, the HSSP-CU will have a contract with four Community-Based Organizations (2 per health zone) to ensure that there is a second level audit of the quantitative and qualitative RBF indicators. During the 2014-2018 period, the GAVI-HSS funds that will be allocated to the 4 Community-Based Organizations for these second-level auditing assignments total US\$ 366,970. The CSOs will also have an important role in implementing health actions at the community level (community activity packages, including promoting immunization, active research on dropouts) in the two health zones targeted for RBF funding.

Part C– Situation Analysis

For further instructions, please refer to the Guidelines for Completing the HSS Application

1. Key relevant health and health system statistics

Key Statistics

Indicator	Source	National Average	Percentage difference between highest & lowest quintiles	Sex			Year
				M	F	T	
Penta3 coverage	Administrative Data	104%					2012
	WHO/UNICEF Estimate	85%					2012
	ESD4	74%	26.9	74.1%	73.3%	73.7%	2012
Coverage for 1 st dose of measles vaccine	Administrative Data	98%					2012
	WHO/UNICEF Estimate	72%					2012
	DHS4	70%	31.0	70.5%	69.5%	70.0%	2012
Dropout rate between 1 st and 3 rd dose of Penta	Administrative Data	9%					2012
	WHO/UNICEF Estimate	N/A					
	DHS4	13%					2012
Percent of districts with DTP3 coverage ≥80%	Administrative Data	97.4%					2012
	WHO/UNICEF Estimate	N/A					
	2008 External EPI Review	74%					2008
DTP3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile	Administrative Data	N/A					
	WHO/UNICEF Estimate	N/A					
	DHS4	26.9	26.9				2012
% of children fully immunized	External EPI review (card+history)	68%					2008
	DHS4 (card)	47.6%	21.3	47.6%	47.6%	47.6%	2012

Additional Health System Statistics

Indicator	Source	Value	Year
Under Five Mortality	DHS4	70‰	2012
Total Expenditure on Health as percentage of GDP	2011 WHO statistic	5.2%	2012
Per capita expenditure on health	2011 WHO statistic	US\$ 74.5	2011
Total health sector budget for the year of application	2013-2015 Program Budget	FCFA 71,790,189,000 (US\$ 143,580,378)	2013
Percent of the health sector budget funded by the government from domestic sources	2013-2015 Program Budget	79.52%	2013
Budget of EPI program for the year of application	2013-2015 Program Budget	FCFA 3.080.000.000 (US\$ 6.160.000)	2013
Percent of subnational level facilities with cold chain capacities fit for purpose (based on WHO definition of “fit for purpose”)	Benin 2014-2018 cMYP	66%	2013
Timeliness and completeness of center and district (or equivalent) reports	2012 Statistics Yearbook	Timeliness = N/A Completeness = 95%	2012
	2013 DQRC (2012 SNIGS data)	Completeness reporting for health facilities = 94.8% Data completeness (no missing data and/or zero) = 99.3%	2012

- There are significant differences between the coverage rate shown in Benin's administrative data and that shown in the 2012 DHS4 survey (30 points difference for Penta3). The WHO/UNICEF estimates are also significantly less than what the administrative data show (19 points difference for Penta3).
- The 2013 DQRC that addresses the 2012 SNIGS data shows consistency between the Penta3 data listed in the source records and those reported in the monthly health facility SNIGS reports (consistency index = 1.01; N= 89). The DQRC also shows that the differential between the administrative Penta3 coverage rates and the coverage rates estimated in the DHS4 survey is relatively homogeneous from one department to another. Finally, the DQRC shows that the denominator (children under 1 year) used by Benin to calculate immunization coverage rates is low in relation to the calculated substitution denominator (consistency index 0.71%).
- These elements support the hypothesis that the very high rates of immunization coverage calculated using administrative data (for example, Penta3 = 104%) could be explained by under-estimating the number of children under one year (numerator), which does not exclude the possibility of over-notification by immunization workers in the source records and/or repeated immunizations of the same child (only 54% of children had an immunization card during the 2012 DHS4 survey).
- The results from the 2012 general population census should allow for the immunization target populations to be updated. In addition, the 2013 DQRC (period under review: 2012) helped identify weaknesses in SNIGS data quality, the health zones that are the most problematic and on which the MoH should concentrate its interventions, such as those defined in the plan to strengthen SNIGS. The MoH will develop an annual DQRC

to monitor and evaluate the progress achieved toward improved quality of health information. Finally, the MoH plans to carry out regular immunization coverage surveys to be able to make realistic official annual immunization coverage estimates using corrected administrative data.

The table below, taken from the 2012 DHS4 survey report, shows that in Benin there is practically no difference in immunization coverage between children of different genders. Girls usually have an immunization coverage rate that is slightly higher than that of boys.

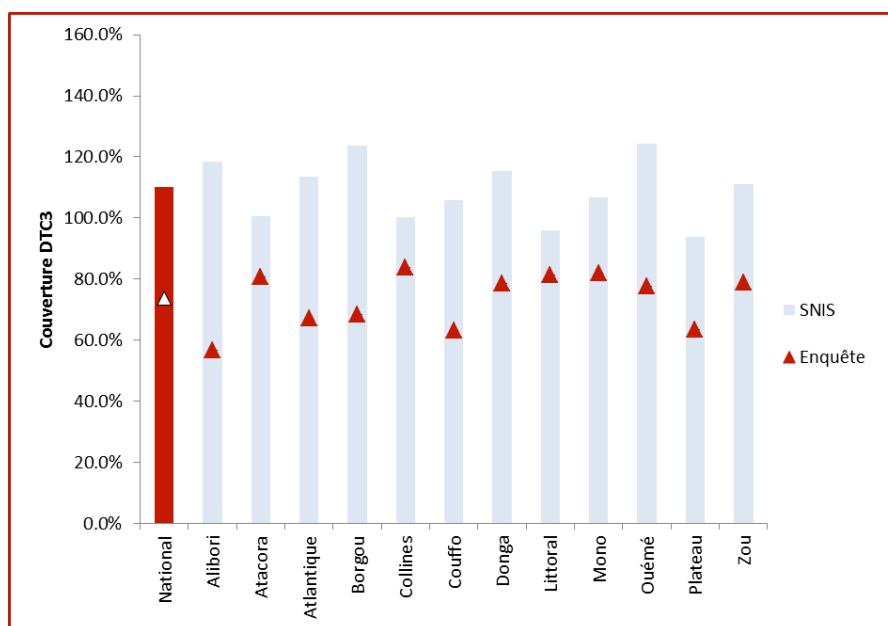
Socio-demographic feature	BCG	DTP ¹			Polio				Measles	All vaccine ^{s3}	No vaccine	HepB+ Hib1	HepB+ Hib2	HepB+ Hib3	Vitamin A	% presenting an immunization card
		1	2	3	0 ²	1	2	3								
Sex																
Male	87.7	85.2	81.6	74.1	81.1	83.8	78.6	56.2	70.5	47.6	10.3	36.2	35.1	33.1	60.1	53.4
Female	88.8	85.7	81.6	73.3	82.5	86.0	79.3	56.3	69.5	47.6	9.0	37.6	35.6	33.3	60.2	55.2

The 2012 DHS4 shows that there are significant geographic disparities in immunization coverage; the departments of Alibori de Atlantique, Borgou, Couffo and Plateaux are the ones with the lowest levels of immunization coverage. These are also the departments for which the differences between the routine immunization coverage data and the DHS4 data are the most significant (see following table). In 2008, 26% of the health zones had a DTP3 immunization coverage lower than 80% (external EPI audit).

EDS4 2012: IC per department

Departments	Penta 3
Alibori	56.7
Couffo	63.2
Plateau	63.3
Atlantique	67.2
Borgou	68.5
Ouémé	77.6
Donga	78.6
Zou	78.7
Atacora	80.8
Littoral	81.3
Mono	81.8
Collines	83.9

DQRS 2013: administrative IC comparison and DHS4



2. Description of the National Health Sector

BACKGROUND INFORMATION

- According to the provisional results of the 2012 RGPH4 census, the population of Benin is 9,983,884, including 5,115,704 females (51.2% of the total population), which corresponds to a ratio 95.3 men per 100 women. Average population density is 87 inhabitants per square km.
- The poverty rate is 30.1% (2012). The poverty index is 37%. In 2012, life expectancy was estimated at 60.2 years for the overall population. For men, life expectancy is 59 years and for women, 61.6 years.
- The under-five mortality rate is estimated at 70 per 1000 live births (DHS4 2012) and the maternal mortality rate is 350 per 100,000 live births (2012 WHO estimate).

Benin's National Health System

- The national health system has a pyramid structure with three levels: Central or National, Intermediate or Departmental, and Peripheral.
- The mission of the central or national level is to design, implement, monitor and evaluate State health policy. The Health Department Directorates (HDD) are part of the intermediate level of the health system and are its programming, integration and coordination entities for all health-related actions that take place at the departmental level. The peripheral level makes up the bottom of the health pyramid and includes 34 health zones throughout the national territory; the health zone is the operational entity that is the most decentralized within the health system.
- In 2012, public health facilities included the National University Hospital Center (CNHU), a Mother and Child Hospital (HOMEL), five (5) Departmental Hospital Centers, 26 zone hospitals and 756 health centers. Benin has a number of significant private facilities (2,197 in the 2012 census) and traditional medicine practitioners. The number of hospital beds (health zone, department hospitals, national university hospital center, HOMEL) in 2012 was 4,794 and the ratio of the number of hospital beds per inhabitant is 1 per 1,953.
- National mapping of private health facilities in 2012 shows that 61.94% are private and for profit, 32.13% are NGOs, 5.60% are religious based and 0.33% are categorized as "Other." 44.3% of their activity can be classified as curative care.
- For service coverage, the mean theoretical radius for an intervention, for the entire country, is 7 km. However, a regional disparity exists ranging from 1.2 in Littoral to 11.4 in Alibori (Atacora 9.3; Atlantique 3.5; Borgou 9.6; Collines 8.1; Couffo 3.6; Donga 8.8; Littoral 1.2; Mono 3.1; Ouémé 2.3; Plateau 4.5; Zou 4.7). The coverage rate in Benin health centers in 2012 was 88.3%. However, most do not meet standardized norms.

Providing services

According to the 2013 SARA assessment:

- the general operational capacity service index is 59%;
- 3% of health facilities have all of the 7 tracer elements.
- For all the health facilities surveyed, the average availability of essential drugs is 40%,
- The lowest average availability scores are related to diagnostic capacity (32%) and essential tracer drugs (40%). About eight (8) out of ten (10) health facilities offer prenatal care (83%).
- Iron and folic acid supplements are available in 83% and 82% of health facilities, respectively.
- With regard to Intermittent Preventive Treatment for malaria, the tetanus vaccine and the monitoring of hypertension linked to pregnancy, coverage rates are 81%, 74% 60%, respectively.
- For EmONC, obstetrics services are available in 70% of the health facilities surveyed. The availability of

obstetrics services is 83% of public health facilities as opposed to 45% of private health facilities.

The health service participation rate in 2012 was 51.4% and the assisted birth rate 93.8%. Penta 1 and Penta 3 coverage in 2012 was 85.4% and 73.7% respectively and the number of health zones with Penta 3 coverage higher than 80% was 74%. The Cesarean rate was 7.8 % in 2012.

Regarding all of the above, the strengths and weaknesses related to care offerings can be summarized as follows:

- Coverage within the health infrastructure has improved in recent years, but disparities exist, particularly within the departments of Zou / Collines where the coverage rate in health centers (76%) is below the national average. 40% of these facilities do not meet standardized norms.
- With regard to immunization, weaknesses are related to the high vaccine wastage rate for certain vaccines, inadequate storage capacity at the national, intermediate and peripheral levels, particularly when a new vaccine is being introduced, inadequate stock management supervision, the lack of a maintenance plan.

Human Resources

- In 2012, Benin had 1,601 doctors, or 1.7 doctors per 10,000 inhabitants; 5,138 nurses, or 2.7 nurses per 5,000 inhabitants and 1,480 midwives, or 3.3, midwives per 5,000 women of childbearing age. These rates are higher than the WHO standard (1 doctor per 10,000 inhabitants, 1 nurse per 5,000 inhabitants and 1 midwife per 5,000 women of childbearing age)
- Human Resources for Health (HRS) policy is affirmed within the National Human Resource Development Plan (NHDPHRS) and NHDP for 2009-2018 which established valuing human resources as a priority.
- Three large programs were developed to take address these priorities within the development of HRS. They address: i) strengthening HRS planning; ii) improving the creation and development of skills; iii) the improvement of the HRS management system.

Supply and distribution of vaccines and other inputs

- Under the African Vaccine Independence Initiative (VII), the country's supply of vaccines is assured by support provided by UNICEF. Immunizations are ordered through UNICEF; the government of Benin has signed a technical support agreement with UNICEF for the purchase of vaccines and supplies. The purpose is to strengthen the methods for evaluating vaccine quality and immunization equipment when they are received.
- Central Purchasing for Essential Drugs and Medical Supplies (CAME) was established in 1991 and has been governed since 20 January 2010 by the 1901 law regulating Associations and is subject to Government control. Central Purchasing is responsible for supplying public and private not-for-profit health facilities as well as pharmacies with essential generic drugs and medical supplies that are considered basic necessities. Central Purchasing was created as the result of a wide consensus between Benin's administration, Development Partners active in the health sector and local communities.
- It has a flexible structure and a national storage facility based in Cotonou and two (2) regional storage facilities, one in Parakou and one in Natitingou, that supply all the health facilities in the country. CAME's annual sales were estimated to be CFA 3,554,871,904 in 2011. Reforms are underway to finalize the legal status of CAME and to improve its information system and management. These reforms address registering CAME's status with the Prefecture, updating management software and relocating facilities due to the current lack of usable space available as well as general company governance.

Health Information

Monitoring and evaluation is based on the routine National Information and Health Management System (SNIGS) and other studies and surveys.

SNIGS' main mission is to maintain quality information to be shared for decision making. To do so, it depends on the health system's organization (health pyramid). Successive assessments that have been performed have shown improvements as well as weaknesses (the incompleteness of reports, less than 10% of private health facilities are included; the under-utilization of data generated by the system; lack of resources; poor quality data,

an average margin of error higher than 15%; lack of understanding targets, etc.). Several problems exist that can be summarized as follows:

- SNIGS health coverage is particularly inadequate for private health facilities in that information supplied by SNIGS is not comprehensive
- In general, the completeness rate is low
- The lack of qualified human resources
- Certain information required for implementing the proposal is not always available at the date needed (current status for infrastructure and equipment in health facilities, etc.).
- The fact that data is not being used at the operational level of the health pyramid for decision-making

With a view toward overcoming these weaknesses, a plan for strengthening has been developed and is made up of the following axes:

- Axis 1: Strengthen system coordination;
- Axis 2: Creation of relevant, comprehensive and quality information within deadlines;
- Axis 3: Development of a national health observatory;
- Axis 4: Strengthening of system resources

Participation of communities and other local participants to strengthen the health system

- The Management committees within the health centers, Zone hospitals, Boards of Directors for Departmental Hospital Centers supervise and audit health service management.
- For service delivery points, community liaisons, not-for-profit health facilities (religious, humanitarian and NGO) participate in services offered in compliance with national directives on care.
- To encourage community participation, the community RBF has been financed by UNICEF since 2011 and to make it sustainable, local authorities are asked to contribute. With the new RBF framework for the HSS, World Bank, GAVI and Global Fund platform, it is recommended that the community RBF be implemented in all target zones so that Benin can meet its MDG goals in 2015.

Legal, policy and regulator environment

- Legally, Benin has an approach that includes a public health code and Law No. 97-020 of 17 June 1997 establishing the conditions for private practice of medical and paramedical professions (Decree No. 3667/MP/SGM/DNPS/SSHCC establishing the conditions and standards for health establishments subject to Law No. 97-020 of June 1997; Decree No. 4139/MSP/SGM/CTJ/DPF/DNPS/CGP/EJ/SA addressing the creation, attribution, composition and operation with the framework of coordination between public and private sectors within the health domain, etc.)
- With regard to policy, Benin has a NHDP (2009-2018); a national pharmaceutical policy document; the seventh edition of the national list of essential drugs (LNME) that is in the process of being validated; and also a document addressing policy and development strategy as a partnership with the private and public sectors, within the health domain.

Benin has the regulatory entity, the Directorate of Pharmacy, Drugs and Diagnostic Examinations (DPMED). The MoH has a General Inspection (that has authority over pharmaceuticals) and regulatory and audit entities for procurement. There is also a very active national order of pharmacists.

Funding the community health system

The Ministry of Health's budget increased from 38 billion in 2002 to 111 billion in 2009 before dropping to 66 billion in 2012.

Health funding is assured by the State, local authorities, households, companies, NGOs and external funding.

Health funding sources	NHA 2003	NHA 2008
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Households	52.1%	42%
State	30.8%	31.82%
TFP	16.5%	20%
Local communities	0.10%	0.28%
Companies	0.5%	3%
ONG	0.0%	2.9%

Source: NHA, 2003-2008

Notable programs applying results based financing include the Program to Support Strengthening Health Zones, funded by the *Coopération Technique Belge*, the Project to Strengthen Health System Performance funded by the World Bank, the community RBF funded by UNICEF and USAID. Furthermore, implementation of RBF for the entire country is currently being negotiated with the Global Fund, USAID and GAVI.

3. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

Benin has a national health policy and a National Health Development Plan (NHDP in appendix) for the 2009-2018 period. This document translates the country's vision that, in 2025, it will have an effective health system based on public and private and individual and group initiatives for the ongoing provision and availability of quality, equitable, accessible care to the populations of all categories, founded on the values of solidarity and risk-sharing to meet all health needs of the Beninese people.

The NHDP has three main objectives:

1. Ensure universal access to quality health services to attain the MDGs;
2. Strengthen the partnership for health;
3. Improve the governance and management of resources in the health sector.

Within the various problems that have been identified, five (5) priority intervention areas have been defined. These are broken down into 13 priority programs and 39 subprograms. Specific objectives have been defined for each area, program and subprogram

The five priority areas are the following:

1. Reduction of maternal and infant mortality, prevention, disease prevention and improved quality of care,
2. Development of human resources,
3. Strengthening of the sector partnership, promotion of ethics, and physician responsibility,
4. Improvement of the sector's funding mechanism,
5. Strengthening of sector management.

Child immunization is a priority strategy of the subprogram for preventing infant and child mortality, the general objective of which is to target the reduction of the under-five morbidity and mortality rate.

In compliance with cMYP 2014- 2018, the specific objectives are:

- To reduce dropout rates between Penta 1 and Penta 3 to 10% in 90% of districts by 2018.
- Immunize at least 95% of children for polio during mass immunization campaigns or follow-up campaigns between 2014 and 2018;
- Provide measles immunization for least 95% of every child aged 9 to 59 months in the country during the follow-up campaigns in 2014 and 2017
- Maintain the elimination of maternal and neonatal tetanus: maintain the occurrence of neonatal tetanus at less than 1 per 1000 live births the occurrence of MNT per year and per commune by 2014;

- Increase the number of communes reporting Yellow Fever from 55% to 80% by 2018;
- Immunize at least 95% of the expected target population against for Yellow Fever in high-risk communes by 2018;
- Immunize at least 91% of the target group for pneumococcus by 2018;

The 2009-2018 NHDP has not been subject to a JANS-type joint assessment. Developing and validating the plan was achieved by focusing on a widely inclusive, participatory process and consensus building.

The 2013-2015 3YDP and the Country Health Policy Process (CHPP) were approached in the same way and are in the process of being finalized. Validation of these plans is scheduled for October 2013.

An NHDP monitoring and evaluation plan was developed in 2012. This plan provides for a mid-term NHDP evaluation in 2015.

4. Monitoring and Evaluation Plan for the National Health Strategy

The Monitoring and Evaluation Plan and Review (PSER) for the 2009-2018 NHDP was developed and validated in 2012. It takes into account the essential indicators related to the NHDP areas and programs and covers all the health-related MDG indicators. It defines the coordination mechanisms for all levels of the health system pyramid. Different data sources were used (SNIGS; DHS; EMICOV *Integrated Modular Survey of Household Living*; GPH, and other surveys) to define the base indicator years and values. The targets within the Monitoring and Evaluation Plan and Review have been set assuming that the 2015 MDGs will be met and that there will be a consolidation of achievements between 2015 and 2018.

The objectives of the Monitoring and Evaluation Plan and Review funding are to:

1. ensure that national health information management as well as monitoring and evaluation capacity are strengthened;
2. implement approaches that guarantee timely availability of comprehensive and quality data;
3. improve the system of recording births and deaths and to promote information and communication technologies;
4. improve the monitoring of results;
5. address on a national level the review strategy for maternal and neonatal deaths and the evaluation of the quality of care;
6. improve the monitoring of resources;
7. improve the current review and action system in the sector; and
8. increase lobbying and stakeholders' awareness.

To accomplish this, the Monitoring and Evaluation Plan and Review has 28 tracer indicators, two of which are impact indicators, 11 of which are outcome indicators, 12 of which are output indicators and 3 of which are input/process indicators. Immunization results will be evaluated using tracer indicators which are the proportion of children under 1 who are fully immunized and, indirectly, the mother child mortality rate.

The Monitoring and Evaluation Plan and Review also has a series of indicators specific to the priority programs. The reproductive health program/sub-program to improve the under five rate mortality rate is made up of several indicators related to vaccination and immunization:

- Percentage of Health Zones with a rate of fully immunized children $\geq 80\%$ (target for 2018 = 80%),
- Immunization coverage rate for measles vaccine for children aged 0 to 11 months (target for 2018 = 95%),
- Immunization coverage for Pentavalent 3 (target for 2018 = 95%),
- Dropout rate between Pentavalent1 and Pentavalent3 (target for 2018 $\leq 10\%$),
- Number of new cases of polio recorded per year,
- Rate of non-polio AFP
- Proportion of communes that have reported at least one case of neonatal tetanus per thousand live births with response,

- Measles prevalence rate
- Incidence of yellow fever
- Prevalence of viral hepatitis B,
- Prevalence of haemophilus infections.

The mechanisms for NHDP monitoring and evaluation depend on SNIGS, on the different sub-systems for collecting and analyzing data which have been implemented within the programs and certain surveys. The Monitoring and Evaluation Plan and Review survey schedule shows a DHS every five years (the last one occurred in 2012), a general census population every 10 years (the last one occurred in 2012) and surveys on immunization coverage (the last one occurred in 2008). In 2013, Benin carried out its first evaluation of Service Availability and Readiness Assessment (SARA) and foresees this being officially carried out on a bi-annual basis.

The Monitoring and Evaluation Plan and Review also provides for mechanisms that target improving the quality of SNIGS data, and, in particular, having a system data quality audit at all levels of the health pyramid, a systematic internal data quality report at each facility identified as responsible for NHDP performance and an annual SNIGS data quality evaluation using DQRC (last one occurred in 2013). Following a rapid assessment of SNIGS carried out in 2011, a 2011-2015 improvement plan was developed and as a result, the 2011 assessment was very limited due to lack of funding.

The table below shows the main surveys carried out or to be carried out for the 2012-2020 period.

Indicators/surveys	2012	2013	2014	2015	2016	2017	2018	2019	2020
Immunization coverage			X(UNICEF)				X(GAVI)		
MICS		X			X			X	
DHS	X				DHS-5				X
DQRC		X	X	X	X	X	X	X	X
SARA		X	X	X		X		X	
EVM	X			X			X		

The different monitoring and evaluation plans for specific programs (EPI, PNT, NPSA, PNLP, PNLMT, PNLMT, etc.) have been aligned with the NHDP plan. To avoid a system that collects and reports data in duplicate, within its own system, SNIGS integrates most of the collection tools for the different specific programs. This information is also periodically sent to SNIGS which then analyzes it and integrates it into the national Health Statistics Yearbook. The latter document serves as repository for historical information for stakeholders at all levels.

Monitoring NHDP implementation is the responsibility of the following key entities and mechanisms:

- At the national level, the National Committee for Monitoring Project and Program Performance and Evaluation (CNEEP - *Comité National de suivi de l'Exécution et d'Évaluation des Projets et Programmes*), was established by decree in 2007 and is presided over by the Minister of Health. This multi-sector entity (that includes CSOs) is in charge of monitoring/evaluation of the implementation of health sector reforms such as those set out in national health policies and strategies and ensure the coordination and alignment of partner actions for health development. It includes a Permanent Secretariat and two sub-committees (monitoring and evaluating the reorganization of the health pyramid and sector resource management sub-committee and also a sub-committee to monitor and evaluate disease and family health). CNEEP has ordinary sessions twice a year and extraordinary sessions if needed. The sub-committees meet on a quarterly basis.
- At the intermediate level, the Departmental Committee for Monitoring Project and Program Performance and Evaluation (CDEEP - *Comité Départemental de suivi de l'Exécution et d'Évaluation des Projets et Programmes*) represents decentralized monitoring and is under the aegis of the Prefect. This entity brings together senior managers from the HDD, HZCD and representatives of ministries that are members of the CNEEP. At the peripheral level (health zone, equivalent to health district), the Health Zone Management Team and the coordination and monitoring entity for the implementation of the operational work plan in a given health area. It has a Management Committee (health, elected officials and CSOs)
- The Interagency Coordination Committee (ICC) is a multi-sector entity in charge of coordinating and M&E for the immunization program.
- The Compact Committee created in 2012 is made up of both government and TFPs and was created to guide the implementation of the sectoral approach being used in Benin as well as to ensure that mutual agreements are respected.
- On a yearly basis, the joint annual health sector performance review (RACPSS) bring together at the national

level the national and departmental figures responsible for the health system as well as representatives from other ministries and institutions, TFPs, civil society and the private sector. This review takes place on a regular basis. Its goal is to monitor and evaluate the implementation of the NHDP and the program operational plans and to also issue recommendations to improve sector performance. At the intermediate level, the departmental joint annual health sector performance reviews (RACPSS in French) have been institutionalized. These RACPSS are scheduled in advance by the national RACPSS. At the peripheral level, an annual performance review of the health zones is also organized annually to evaluate the level of indicators attained for a given year. In addition, the main health programs that are a part of the Expanded Program on Immunization must also be reviewed annually and the results and recommendations from them are used for the RACPSS. It is important to note, however, that these annual program reviews are not systematic and that whether or not they are carried out greatly depends on external financing. The last EPI annual review occurred in 2008.

- The Poverty Reduction Growth Strategy annual review, responsible for monitoring the MDGs, presents the starting point for the following Annual Work Plan to be introduced, in cooperation with the Council of Ministers.
- The quarterly TFP meeting brings together technical and financial partners within the health sector with the Minister of Health and the National Technical Directors. This meeting provides an opportunity to discuss subjects important to the sector and to find solutions. It also a forum for coordination and monitoring of the NHDP implementation.

The mid-term evaluation of the NHDP will take place at the end of 2015 and will mainly address coverage indicators. The final evaluation will take place in two stages:

- 1st stage: the final evaluation will take place at the exact time the NDHP ends in 2018 and will measure progress made toward achieving the sector's objectives
- 2nd stage: post-NDHP evaluation will take place in 2021 at the same time as DHS-BSB VI and will address both coverage indicators and the outcome of the objectives.

5. Health Systems Bottlenecks to Achieving Immunization Outcomes

The main constraints in the health sector's system identified in the analysis of the 2009-2018 NHDP can be summarized as follows:

In terms of leadership and governance:

- Leadership is not dependable, particularly where private sector integration and monitoring are concerned.
- Sector policy and strategy development as well as standards lack leadership. Urban health zones are not the target of any particular strategic approach.
- Poor health administration performance exists at all levels.
- M&E mechanisms do not perform well. Intra-intersector [sic] coordination is inadequate.
- Non-compliance with good governance practices.
- Decentralization of the health sector remains incomplete.

In terms of human resources workforce in health:

- There is a quantitative, qualitative and distribution deficit when it comes to human resources.

- There are large human resource distribution inequalities in the health sector when it comes to the following the Littoral, Oueme and Atlantique departments, as well as the capital, Cotonou.
- Inadequate HR planning and management.
- Initial training that is not always adapted to the needs in the field, unsystematic ongoing training that is not well integrated and is very dependent on the health programs.
- Poorly motivated human resources, resulting in, among other problems, frequent illegal practices and high levels of absenteeism.
- Lack of supervision and auditing.

In terms of physical resources:

- Low level of technical facilities and inadequate management of technical equipment.
- Inadequate vehicle resources.
- Insufficient medical equipment, reagents and technical medical supplies.
- Frequent shortages of essential drugs at the CAME level and storage facilities throughout the zone.
- Weaknesses in the maintenance system.

In terms of funding

- Households still make a very significant contribution to health sector funding (approx. 52%)
- Lack of mutual health insurers and the absence of universal health insurance.
- The portion of the general State budget allocated to health gets smaller every year.
- The procedures for consuming designated credits are too complex.

In terms of service provision

- Inadequate health coverage
- Incomplete health care service offerings that are of poor quality
- Low service usage rates

The Strategic Strengthening Plan for SNIGS (2011-2015) identifies the main weaknesses of the health information system in Benin:

- Lack of an institutional framework for the information sub-systems at the community level and the lack of ongoing trend monitoring.
- The lack of standardized support for administrative and financial management, multiple sources of data coming from programs and projects.
- Poor coordination for SNIGS activities
- Lack of enough quality SNIGS human resources (lack of ongoing training).
- Inadequate global financial resources for SNIGS.
- Insufficient, inadequate or outdated material resources (vehicles, computer equipment, Internet access).
- Collecting data from the private sector is problematic.
- Supervision, monitoring and validation of data that is inadequate at all levels.
- Global use of SNGIS data for planning, management and monitoring of the health system is inadequate.

The 2014-2018 cMYP specifically identifies health system bottlenecks which affect immunization performance:

With regard to services offered

Management of vaccines and cold chain capacity (EVM 2012)

- At the national level, weak points are the procedure for receiving vaccines, storage capacity and vaccine transport, temperature control and maintenance of the cold chain and buildings//logistics. It is important to note that the two positive cold rooms are currently being acquired/installed with GAVI-HSS funding that will contribute to closing the capacity deficit noted in the EVM.
- At the departmental level, there are also vaccine storage capacity and distribution problems and problems with the cold chain and building maintenance. At this level, scores related to vaccine management and temperature control are relatively satisfactory,
- As far as generator or commune storage facilities are concerned, storage capacity and transport, vaccine management and distribution, and cold chain maintenance, remain priority problems.
- At the health center level, maintenance and inventory management are the most problematic areas. Oil-

powered cold chain equipment is obsolete in 56% of facilities and should be replaced by solar refrigerators.

#	EVM 2012 Benin Criteria	Level				
		National	Department	Regional/area	Commune	Health center
1	Vaccine receiving procedures	58%	Not applicable			
2	Temperature monitoring	41%	75%	95%	70%	77%
3	Storage and transport capacity	33%	55%	28%	70%	69%
4	Buildings, equipment and transport	67%	79%	70%	67%	78%
5	Maintenance	50%	55%	59%	63%	54%
6	Stock mgmt.	72%	79%	74%	61%	59%
7	Distribution	64%	31%	32%	57%	69%
8	Vaccine management	68%	81%	57%	62%	80%
9	MIS and Supportive Functions	78%	89%	100%	61%	Not applicable

EPI Logistics

- Inadequate logistical means of supervision on the health zones or for outreach strategies
- Very poor availability of operating incinerators
- Very inadequate equipment maintenance

Planning / management of program and implementation of immunization activities

- Poor planning and budgeting for EPI activities in health zones
- Poor implementation of immunization activities, in particular outreach strategies

Human Resources

- Poorly motivated health personnel, lack of qualified personnel at the operational level
- Insufficient supervision

In terms of immunization demand

- Low percentage of mothers familiar with the immunization schedule, potentially epidemic diseases (PED) and AEFI
- More and more reticence regarding immunization within certain communes, particularly during mass campaigns

In relation to monitoring and evaluation

- Lack of program M&E at the national level
- Poor SNIGS performance (health information, AEFI, EPI disease surveillance)

Financing

- Lack of financial resources to implement immunization activities at all levels

Considering the current situation, GAVI-RSS funds will contribute to removing the following bottlenecks:

- 1. Inadequate coverage of quality health services and immunization in particular, as well as low use of health services,**
- 2. Weak capacity within the cold chain at the department, commune and operational levels, and vaccine management that needs improvement**
- 3. Weak performance of the health information system and under-utilization of data for monitoring and evaluation and strategic planning.**

6. Lessons Learned and Past Experience

Objective	Example(s) of lessons learned, highlighting both successes and challenges
<p>1. Increase coverage of quality health services and specifically immunization services, and the use of health services within the two health zones targeted for implementation of Results Based Financing</p>	<ul style="list-style-type: none"> - In 2007, Benin began testing Results Based Financing (RBF) in three health zones with the support of the BND. The evaluation carried out in 2008 shows that the experience was limited due to operational problems linked to existing financial management procedures that impede rapid transfer to health zones of non-allocated credits. - After several workshops and study trips, the Ministry of Health decided to generalize this strategy by first restructuring the RBF approach. It is important to note that the health worker unions were involved very early in this policy dialog, being that they were initially unfavorable to RBF. They now strongly support this approach. - A strategic document on RBF in Benin was developed in July 2013 with the support of the World Bank. - RBF has been implemented in Benin as a technical partnership with the World Bank, <i>Coopération Technique Belge</i> (CTB), the Global Fund and UNICEF, with the WHO facilitating. Since Mach 2012, Benin has received support from the World Bank to implement RBF in eight health zones (HSSP project). The CTB is planning to implement an RBF approach in five health zones. At this stage, the partnership between CTB and the World Bank is based on sharing knowledge relevant to this approach. The MoH will ensure project coordination and will apply its experiences from implementing RBF in different health zones, specifically its experience with tools and results. UNICEF will also contribute (training, drugs and materials) to eight health zones chosen for the HSSP. This partnership is the subject of a letter of agreement (in the process of being signed) between partners for strengthening the health system (World Bank, UNICEF, CTB, the Global Fund and GAVI). - The different studies and impact evaluations on the implementation of results (or performance) based financing in Africa (DRC, Burundi, Rwanda, etc.) show significantly improved coverage, quality and use of health services. - In Benin, a supervisory mission for the HSSP project that took place in July 2013 has provided the first results from a year of implementing RBF in eight health zones. The results, in terms of change for RBF indicators, are mixed for 2012. Most of the indicators are stagnant. The mission has, however, been able to collect a significant amount of information on the specific causes of this situation. It is clear that the stagnant RBF results are largely linked to delays in payments for health facilities; the first RBF payments to health facilities were not made until the end of 2012. Improvements in the RBF indicators observed at the beginning of 2013 are very encouraging; it must be noted, however, that the this trend must be confirmed for the entire year.
<p>2: Strengthen cold chain capacity at the intermediate level and within the two targeted health zones as well as increase in efficient vaccination management</p>	<ul style="list-style-type: none"> - Over the medium term, it is necessary to anticipate the need for strengthening cold chain capacity to take into account the introduction of the new vaccines planned for the future (MenAfriVac in 2016, HPV in 2017 and Rotavirus in 2018). - considering the obsolete condition of oil-powered refrigerators in health facilities (56% are more than 10 years old) and the cost of oil, it has been recommended that oil-powered refrigerators be replaced with solar ones. <hr/> <ul style="list-style-type: none"> - New solar refrigerators (that do not use batteries) are currently being tested in Benin as part of the Logivac project but it is too early to generalize from the use

	<p>of this equipment to the entire country.</p> <ul style="list-style-type: none"> - Benin' s experience and that of the countries in the subregion show the outsourcing of cold chain maintenance to be efficient - According to the 2012 EVM results, the Ministry of Health should develop an emergency plan for vaccine storage in the event that there is a problem in the cold chain that affects all levels.
<p>3: Strengthen SNIGS and the use of data for monitoring and evaluation and strategic planning</p>	<ul style="list-style-type: none"> - Annual sector reviews have proven their importance for HSS and they merit support so that their quality can be improved. This same comment may be made for the annual EPI reviews; making these systematic is essential. For strategic planning, it is very important that the statistics yearbook for the health sector be published on an annual basis; as a result, it should also receive support. - The quality of SNIGS data could still be improved and requires strengthening quality audits and data validation at all levels within the health system. The DQRC is an efficient tool for this purpose that allows weaknesses to be identified and progress to be measured for the strengthening of data quality. Institutionalization of this should be supported as it is with SARA. An effort at integration and complementarity should be made for data collection and analysis between SNIGS and priority programs. Data integration in the private sector is also a priority. - Benin RBF presents an opportunity to improve the quality and use of health information data at the operational level. Independent entities that verify RBF indicators and the CSOs in charge of providing a second-level audit work together closely with the SNIGS with a view toward strengthening institutions. - A central data repository is being planned using District Health Information Software 2 (DHIS2). This is a web-based platform and it was designed by the University of Oslo. It allows for different subsystems to be easily integrated and it facilitates user access and software maintenance. A consultant is currently being recruited to implement DHIS2 and integrate it with RBF/SNIGS.

PART D - PROPOSAL DETAILS

7. Proposal Objectives

Objective No. 1: Strengthen quality health service and specifically immunization coverage and the use of health services in the two targeted health zones using the implementation of Results Based Financing (US\$ 5,759,434)

This objective addresses removing bottlenecks linked to poor coverage of quality health services and inadequate use of these services. This is included in Benin's 2009-2018 NHDP and, specifically, in priority 1 areas (disease prevention and improved care quality) and priority 2 areas (developing human resources).

The RBF approach was officially launched in Benin in September 2011. This strategy is included in the global framework of the 2009-2018 NHDP, the National Compact signed on 12 November 2010 and the Letter of Agreement to implement strengthening of the health system established between the government and partners (World Bank, UNICEF, CTB, the Global Fund and GAVI). It uses information from diverse studies carried out in Benin (particularly the 2011 Baseline study), lessons learned from the AFBP project (community RBF) financed by UNICEF in four Health Zones, and lessons learned from international experiences. A document on the framework of RBF in Benin was developed in July 2013 to define the modalities and mechanisms for implementing M&E for RBF, as well as the roles and responsibilities of the different stakeholders in this approach. There are appendices defining quantitative and qualitative RBF indicators. This strategic document will serve as reference for all TFP support during implementation of RBF in the country (website: www.beninsante.bj).

Considering the amount of funding available, the implementation of RBF will be applied to GAVI-HSS support in only two (2) health zones. The Tchaourou (Borgou Department) and Sakété-Ifangni (Plateaux Department) health zones were selected due to both health performance criteria and a search for complementarity with the support provided by other TFPs. These health zones include 152,650 inhabitants for Tchaourou and 203,163 inhabitants for Sakété – Ifangni (equaling 3.7% of the country's population). It should be noted that the previous GAVI/HSS proposal addressed 4 health zones selected in complementarity with the positioning of other TFPs for RBF (WB, Global Fund and UNICEF). Considering the limited funding available for the current GAVI/HSS, only 2 of the 4 initial health zones were retained on the basis of their weak immunization performance (see following table). The government negotiated RBF support with the Global Fund for the two remaining health zones. The distribution of the TFP support for Benin RBF in each health zone as well as the amounts involved are addressed in section 12 (gap analysis and complementarity) of this document. Furthermore, the implementation of the RBF approach will be supported in all of the country's 34 health zones if the GAVI/HSS proposal is approved.

Selection criteria for the 2 RBF GAVI-HSS health zones out of the 4 initial health zones

HEALTH ZONES	Coverage		Measles coverage*		BCG - Measles dropout rate			Measles epidemic**		
	Penta 3:									
	2011	2012	2011	2012	2011	2012	1 st S 2013	2011	2012	2013
	80%	81%	80%	82%	20%	20%	20%	Y	Y	Y
	91%	95%	91%	98%	20%	21%	21%	E	E	E
	-	-	-	-	-	-	-	S	S	S
	94%	98%	94%	92%	24%	25%	26%	-	-	-
	-	-	-	-	-	-	-	S	N	S
	-	-	-	-	-	-	-	-	O	-
	-	-	-	-	-	-	-	-	N	-
	-	-	-	-	-	-	-	-	S	-

									E		
Health Zones paid using Global Funds support											
Mal anv ille- Kar ima na	8 6 %	1 0 5 %	8 8 %	1 0 8 %	1 4 %	1 1 %	1 1 %		N O N E	N O N E	N O N E
Apro Misserete Avr ank ou- Adj arr a	1 1 6 %	1 1 7 %	1 0 9 %	1 1 0 %	2 1 %	1 6 %	1 6 %		N O N E	N O N E	N O N E

* immunization coverage according to administrative data (overestimate)

** Statistics Yearbook

The Benin RBF strategy has three main principles:

- Funding health facilities with a purchasing contract and on the basis of their performance as related to health service offerings measured by indicators that are both quantitative (weighted) and qualitative. These indicators are targeted at high-impact health interventions.
- Separating the functions of the buyer, the auditor/second-level auditor, regulator and care providers. The entity in charge of the final performance audit is an independent entity.
- Strengthening health facility management autonomy and making participants responsible.
- Improving equity (bonus for geographic equity and indigence indicators)
- Involving communities in performance monitoring and evaluation and in decision-making
- With regard to funding, at least 50% of funding from RBF must be used for health facility operations and the implementation of priority health programs. A maximum of 50% of credits are to be allocated as health worker bonuses related to performance, according to clearly defined rules. It is important to note that a maximum 5% of upstream RBF funding is allocated to infrastructure and regulatory facilities (MoH, HDD and Health Zone Management Teams at the national level) on the basis of their performance to accomplish their respective missions, measured using specific indicators.

The impact of the RBF approach on supply and demand of care-related services is summarized in the following table

Technical quality of service offerings	Somewhat Positive	Increased bonuses and an improved work environment will attract a higher quality of personnel. Bonuses can be used for ongoing personnel training and improved technical support.
Quality of service	Positive	Considering the RBF qualitative indicators, the bonuses encourage health workers to increase availability and operational capacity of services as well as the quality of global care offered to patients
Quantity of service offerings delivered / use of services	Positive	Quantitative indicators will result in improvements for targeted (high-impact) activities. The RBF also provides for the funding of "community liaisons" to implement a package of community activities and, in particular, information/awareness and the health promotion. There are specific RBF indicators linked to this.
Efficient allocation of resources	Positive	The RBF approach will encourage health facilities to produce more results with the available resources and to allocate them to high-impact, health-related interventions
Equity	Positive	Geographic equity will improve due to use of the remoteness bonus and the incentive to implement outreach strategies targeted at reach remote populations. Finally, two RBF indicators in Benin are related to the use of health services by those who are indigent; this should be an incentive for health personnel to be more welcoming to, and to care for, the indigent. Use of State Funds to Support the Indigent should also then be improved.

Regarding the impact of immunization, it is expected that there will be improved efficiency in immunization

coverage for children and pregnant women. RBF financing will allow, in addition to increasing the motivation of health workers to perform, support for immunization activities (purchase of small equipment, motorbikes, support for outreach strategies, etc.). In addition, RBF performance indicators take immunization outcomes into account, as well as taking into account quantitative and qualitative results at the health facility and the community liaison level. This will modify the incentives for improvement to actual immunization coverage and improved equity where immunization is concerned.

- The quantitative indicators are: Rate for Penta1; Rate children under one year old who are fully immunized according to the vaccination calendar; T^x PNC with TT; to which will be added two specific indicators for the health zones being supported by GAVI-HSS: Rate for Penta3, Rate for the measles vaccine. At the community level, the following indicator will be added: children <1 yr who are fully immunized with community liaison involvement.
- The 12 qualitative indicators related to immunization concern the availability of immunization management, cold chain compliance, immunization equipment, records and the dropout monitoring system. The dropout Rate for Penta 1/3 was added to GAVI-HSS. These are indicators of availability and operational service capacities, certain of which are common to SARA.

The main activities supported by GAVI-HSS using the RBF strategy in the two health zones are the following:

1. Strengthen logistic capacity in the two targeted health zones
 - Procure vehicles for health facilities and HDD
 - Procure computer equipment
2. Improve skills and motivation for participants in the health system, including the EPI
 - Organize two 5-day training sessions for RBF trainers for 25 participants
 - Organize three 5-day RBF training sessions for 30 participants
 - Organize four 5-day training sessions on managing obstetrical complications for 30 participants each
 - Allocate performance-based credits to the health zones
 - Organize an annual RBF workshop
 - Responsible for participation of 2 medical specialists per health zone (pediatrics, OB-GYN)
3. Improve community participation in implementation of health activities including immunization
 - Ensure that 4 CSOs are providing a second-level audit of the data (2 per health zone)
 - Organize four 4-day training sessions for 30 CSO participants per session on RBF and second-level data audits
 - Organize a 4-day training session on RBF for 35 local radio hosts
4. Ensure the management and monitoring of RBF contracts by the health facilities in the two health zones
 - Ensure the involvement of an external technical audit firm for data created in the two health zones
 - Procure supervision vehicles for the outside audit firm for auditing activities in the two health zones
 - Procure computer and office equipment for the outside audit firm for auditing activities in the two health zones
 - Cover the audit firm's administrative costs
 - Pay performance contracts in force for the ten national and decentralized facilities (Health Zone Management Teams, 1 HDD, NDPH, HRD and ANV/PHC) for regulation and M&E
 - Evaluate zone hospital service quality on a quarterly basis
 - Implement the EPI communication plan
 - Update the RBF portal so that the two GAVI zones are included there;
 - Ensure 15-day bi-annual internal audits to be carried out by three IGM workers in the two zones

Objective No. 2: Strengthen cold chain capacity at the intermediate level and within the two targeted health zones as well as increase in efficient vaccination management (US\$ 895,555)

This objective addresses removing bottlenecks linked to insufficient cold chain capacity at the department and operational levels so that EPI vaccines are conserved, as well as targeting the weaknesses that exist in vaccine management. It is directly included in the framework of 2012 EVM recommendations, the vaccine management improvement plan, and the 2014-2018 cMYP. This is also included in Benin's 2009-2018 NHDP and, specifically, in priority 1 areas (disease prevention and improved care quality) and in the subprogram to prevent under-five mortality.

The main issue will be to ensure adequate vaccine storage capacity (current vaccines as well as new vaccines to be introduced before 2018) in two departments (Borgou/Alibori and Ouémé – Plateau), the two targeted health zones (RBF) and the immunization storage facilities located in the four (4) related communes. It is important to note that storage capacity at the national level is currently being strengthened by the installation of two cold rooms (GAVI-HSS 2009 support) and that two other cold rooms are being installed at the departmental level (funded by the BND). The other areas affected by efficient immunization management will be strengthened by the GAVI-HSS support by training storage facility workers in the departments, supervision and M&E at the national level, as well as logistical support for the distribution of vaccines and equipment maintenance. An EVM survey will also be carried out in 2015 on GAVI-HSS funding.

By reinforcing the EPI vaccination supply chain, storage and distribution, the result will be improvements in the availability and quality of vaccinations in Benin as well as a decrease in the vaccine expiration rate.

The main activities funded by the GAVI-HSS support are the following:

Act 2.1 Improve immunization storage capacity at the intermediate levels and in the two targeted health zones

Act 2.1.1 Strengthen the cold chain at the departmental level in Borgou/Alibori and Ouémé Plateau and the two targeted health zones

- Provide and install two positive cold rooms in the two departments
- Provide and install refrigerators and freezers in 4 commune storage facilities and 40 health facilities in the two targeted health zones

Act 2.1.2 Retrain 10 technicians (6 departmental storage facilities + 2 targeted health zones) on preventive maintenance for the cold chain and immunization management

Act 2.2 Ensure a maintenance of cold chain equipment

Art 2.2.1 Cold chain maintenance for the 2 departments and the 2 health zones

Act 2.3 Strengthen management and distribution capacity for immunizations and supplies

Act 2.3.1 Strengthen capacity of the workers in charge of logistics in the departments of Borgou/Alibori and Ouémé Plateau and the two targeted health zones

Act 2.3.2 Ensure quarterly supply by central level of 9 regional storage facilities for EPI immunizations and supplies and carry out quarterly supportive supervision of the cold chain and immunization management for the two health zones

Act 2.4 Ensure M&E of efficient immunization management and the cold chain at the national level

Act 2.4.1 Carry out a national EVM survey

Act 2.4.2 Ensure bi-annual cold chain supervision and evaluation by the central level in the 6 departments

Objective 3: Strengthen SNIGS and the use of data for monitoring and evaluation and strategic planning (US\$ 960,418)

This objective supports removing bottlenecks linked to weak performance within the national health information and management system and under-utilization of data for M&E and strategic planning.

This is included in the 2009-2018 NHDP and, specifically, in priority area 6 (strengthening management of the sector) and the sub-program to strengthen planning, coordination and evaluation capacity. This is also included in the strategic plan to strengthen SNIGS (2011-2015) and will contribute to its implementation.

It specifically addresses the availability and quality of health data to be used to strengthen the capacity of SNIGS workers, the systematic supervision and quality control and validation of these data, as well as carrying out surveys and related studies. Holding annual EPI program reviews will also be supported. Finally, an external audit of GAVI-HSS will be carried out. It is important to also note that the implementation of the RBF strategy will permit strengthening SNIGS in the two targeted health zones (monitoring, audit, second-level auditing of qualitative and quantitative indicators). Better production and use of health information will allow for improving the quality of annual sector and program reviews.

Concerning the EPI, strengthening the health information system (improving data quality, dissemination and use) will allow for better M&E of program performance, improved decision making, corrective measures and better strategic planning of immunization interventions that contribute to strengthening actual immunization coverage as well as its level of equity.

The main activities implemented by the GAVI-HSS support are the following:

Act 3.1 Strengthen capacity of SNIGS workers in charge of collecting and using data

Act 3.1.2 Support the organization of a 5-day national workshop for 78 people to revise and standardize SNIGS data collection materials

Act 3.1.3 Ensure a first publication of edited SNIGS materials

Act 3.1.4 Organize three 3-day sessions in a national "training for trainers" on updated SNIGS data collection tools for a total of 55 participants (HDD and health zones)

Act 3.1.5 Organize three-day training workshops for 80 collection workers in the two targeted health zones

Act 3.1.6 Support publication of national health statistics yearbook addressing how to fill out collection tools

Act 3.1.7 Support organization of 2-day annual EPI thematic reviews

Act 3.1.8 Organize bi-annual 3-day workshops to validate SNIGS data in the 6 HDD with the support of the central level (total of 92 participants + 9 facilitators)

Act 3.2 Conduct periodic data quality audits at the community health system level

Act 3.2.1 Draft the national-level DQRC

Act 3.3 Organize surveys, including immunization surveys, studies and operational research

Act 3.3.1 Organize a SARA survey + a SNGIS data audit module

Act 3.3.2 Organize a national survey on immunization coverage

Act 3.3.3 Organize a final GAVI-HSS evaluation

8. Results Chain

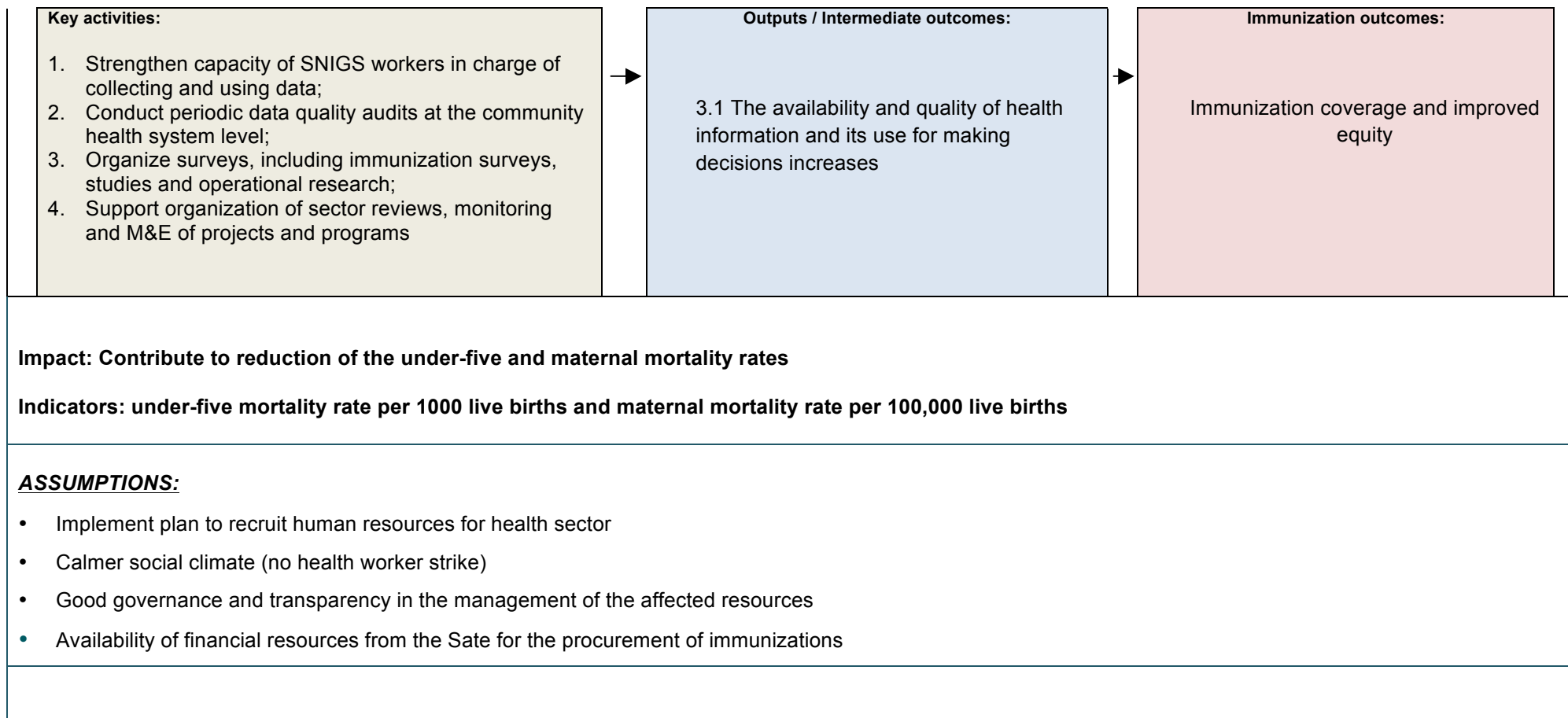
Objective 1: Increase coverage of quality health services and specifically immunization services, and the use of health services within the two health zones targeted for implementation of results based financing

<p>Key activities:</p> <ol style="list-style-type: none"> 1. strengthen logistic capacity in the two targeted health zones <hr/> <ol style="list-style-type: none"> 2. Improve skills and motivation for participants in the health system, including the EPI 3. Improve community participation in implementation of health activities including immunization 4. Ensure the management and monitoring of RBF contracts by the health facilities in the two health zones 	<p>Outputs / Intermediate outcomes:</p> <ol style="list-style-type: none"> 1.1 The availability and operational health service capacity, including immunizations, are strengthened in the two targeted zones 1.2 Awareness and the participation of communities in health services, including immunizations, increase in the two targeted zones 	<p>Immunization outcomes:</p> <p>Immunization coverage and improved equity</p>
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Objective 2: Strengthen cold chain capacity at intermediate levels and in the two targeted health zones as well as efficient immunization management

<p>Key activities:</p> <ol style="list-style-type: none"> 1. improve immunization storage capacity at intermediate level and in the two targeted health zones <hr/> <ol style="list-style-type: none"> 2. Strengthen management and distribution capacity for immunizations and supplies 3. Ensure a maintenance of cold chain equipment 4. Ensure M&E of efficient immunization management and the cold chain at the national level 	<p>Outputs / Intermediate outcomes:</p> <ol style="list-style-type: none"> 2.1 Cold chain capacity is strengthened at the intermediate level 2.2 The quality of vaccine management is improved at all levels 	<p>Immunization outcomes:</p> <p>Immunization coverage and improved equity</p>
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Objective 3: Strengthen SNIGS and the use of data for monitoring and evaluation and strategic planning



9. Monitoring & Evaluation Plan

The monitoring and evaluation system for GAVI-HSS support depends on the entities and mechanisms that exist within the Ministry of Health. It is integrated into the M&E 2009-2018 NHDP plan.

The main entities and mechanisms are the following:

- The National Committee for Monitoring Project/Program Performance and Evaluation (CNEEP), chaired by the Minister of Health, is a multi-sector entity (that includes CSOs) that is in charge of monitoring/evaluation of the implementation of health sector reforms such as those set out in the health sector, and in particular, those implemented through the NHDP.
- The Coordination Committee for Health System Strengthening (CC-HSS) was created in 2011. It is chaired by the Minister of Health and its mission is M&E and coordination of all HSS activities. This multi-sector committee (MoH, MEF, MFSN) integrates TFPs (WHO + Lead health TFP) will be enlarged by the inclusion of CSOs.
- The Directorate for Planning and Forecasting includes:
 - SNIGS, responsible for collecting, validating analyzing and disseminating health information;
 - the M&E Unit (CSE) in charge of monitoring, implementing the program budget and recommendations from the sector's large events, drafting performance reports and organizing a joint performance sector review;
 - An RBF unit to approve and make the achievements of the RBF approach implementation sustainable in Benin (currently being created).
- The Health System Strengthening Project - Coordination Unit (HSSP-CU), entity charged with, within the Ministry of Health, supporting the implementation and management of all HSS programs in Benin. The HSSP-CU has a financial manager, a procurement specialist and a M&E manager (currently being recruited).

In accordance with the May 2012 Benin-GAVI Aide Memoire, the HSSP-CU will be in charge of developing the Annual Work Plan for GAVI-HSS support while strictly respecting the interventions and annual financial limits defined in the GAVI-HSS Proposal and in the GAVI Decision Letter. These Annual Work Plans will integrate all activities to be carried out for GAVI-HSS support, including activities of the Central Directorate and those of other levels of the health pyramid. These budgeted Annual Work Plans will have classic input indicators and processes that allow the implementation of interventions to be measured. These Annual Work Plans will be validated by the CC-HSS.

The HSSP-CU will be in charge of monitoring the programmatic and financial implementation of these Annual Work Plans. The HSSP-CU will be in charge of the different levels of health administration and of specific RBF monitoring mechanisms. It will draft quarterly situation reports about Annual Work Plan implementation that will be submitted to the CC-HSS.

The DPF will be in charge of data creation and validation for indicators (intermediate outcomes, outcomes related to immunization and impact) noted in the GAVI-HSS monitoring and evaluation plan (Excel file in appendix). To do so, the DPF will use different systems to collect and analyze SNIGS data and Ministry of Health programs as well as specific survey results.

Using the official database created by the DPF, the HSSP-CU will be responsible for drafting quarterly and annual progress reports (APR) for GAVI-HSS support. These reports will be validated by the CC-HSS before being sent on to the GAVI Secretariat within the deadlines. These reports will also provide information to be used in the annual health sector reviews.

The monitoring and evaluation of quantitative and qualitative RBF indicators will be carried out by the HSSP-CU according to the specific modalities defined in the strategic RBF document for Benin. The HSSP-CU will support the (independent) Zone Auditors for indicator auditing and with the Community-Based organizations under contract to provide second-level auditing of indicators. The monitoring of indicators will be carried out in close collaboration with the decentralized health administration that plays the role of regulating the health system.

The M&E plan in appendix details the indicators used, reference values and target values as well as collection sources. The following table summarizes the main points:

Indicator	Reference source	Target value source	Sources / Observations
Impact			
Under-five mortality rate	2012 DHS-4	2016 and 2019 MICS Survey	The targets may be revised if there is a reinterpretation of

		2016 DHS-5	the NHDP/Monitoring and Evaluation Plan and Review, following the mid-term evaluation planned for 2015
Maternal mortality rate	WHO Estimate	2016 and 2019 MICS Survey	The targets may be revised if there is a reinterpretation of the NHDP/Monitoring and Evaluation Plan and Review, following the mid-term evaluation planned for 2015
Immunization outcomes			
Penta3 coverage in children < 1yr	2012 DHS-4	Official Country Estimate	Official estimate established using corrected administrative data taking updated survey coverage results and EPI target populations into account using the 2012 GPHC results. Considering the unrealistic nature of the immunization coverage calculated using administrative data (denominator problem) the targets in relative value were established using reference values from the 2012 DHS4. The targets in terms of absolute value were established using the number of children immunized in 2012 (administrative data) by applying the same growth factor as that used to establish target coverage rates. A substitution denominator was calculated to match the target coverage rates.
MCV1 coverage in children < 1yr			
% Penta3 districts > 80%	2008 External Review	Official Country Estimate	Official estimate established using corrected administrative data taking updated survey coverage results and EPI target populations into account using the 2012 GPHC results.
Penta3 differential household wealth index, the richest, the poorest	2012 DHS-4	2016 DHS-5 2016 and 2019 MICS	SNIGS does not allow for calculating this indicator
Penta1/3 Dropout rate	2012 DHS-4	Official Country Estimate	Established using corrected administrative taking survey coverage results and 2013 RGPH into account
Intermediate outcome indicators			
Disbursement Rate of RBF funds in the two health zones	<u>Annual UCP-HSS Report</u>	<u>Annual UCP-HSS Report</u>	<u>Programmatic and financial report for the two targeted health zones. Score takes into account all quantitative and qualitative RBF indicators for the creation and use of health services, including vaccination</u>
Disbursement rate for RBF funds for community liaisons in the two health zones	<u>Annual UCP-HSS Report</u>	<u>Annual UCP-HSS Report</u>	<u>Programmatic and financial report for the two targeted health zones. 6 quantitative RBF community criteria</u>
Yearly average rating earned by the two health zones for the qualifying RBF criteria for area 8 (immunization and monitoring of infants and children under 5)	<u>N/A</u>	<u>Annual UCP-HSS Report</u>	Programmatic and financial report for the two targeted health zones. 10 RBF qualitative criteria related to area 8 (and, in particular, the availability and operational service capacity for immunization). Maximum 130 points. Data validated by the external audit office
Success rate for storage capacity needs at the intermediate level for all	<u>EVM 2012</u>	Cold chain inventory,	Positive cold chain capacity for all immunizations (traditional and new immunizations)

immunizations		annual EPI review report.	
Proportion of evaluation criteria for efficient immunization management with values greater or equal to 75% (national and intermediate levels and health centers)	EVM 2012	Source 2015 and 2018 EVM	Proportion out of a total of 40 criteria/levels (9 criteria for the central level, 8 criteria for the departmental level, regional liaison, communes and health center)
Vaccine stock shortage rate	SARA	EPI + SARA Monitoring	Stock shortage rate calculated for penta and measles vaccines
Immunization completeness data rate	2013 DQRC	DQRC	DQRC carried out in 2013 but related to SNIGS 2012 data. A DQRC will be conducted every year
SNIGS consistency index (using 4 weighted indicators)	2013 DQRC	DQRC	DQRC carried out in 2013 but related to SNIGS 2012 data A DQRC+ SNIGS data verification module will be conducted every year (SNIGS module will be integrated into SARA every two years and applied/filled out separately between two SARA surveys)

The following table shows the survey plan required to measure the GAVI-HSS indicators

Indicators/surveys	2012	2013	2014	2015	2016	2017	2018	2019	2020
Immunization coverage			X(UNICEF)				X(GAVI)		
MICS		X			X			X	
DHS	X				DHS-5				X
DQRC		X	X	X	X	X	X	X	X
SARA				X		X		X	
EVM				X			X		

10. Procedure for completing the proposal

HSCC/ICC and cooperation between the EPI, other departments and entities at the sub-national level (provincial, district) of the Ministry of Health and the private sector when completing the proposal

This proposal was developed using a participative process including all stakeholders, steering committee meetings, group work on retraining, cooperation with civil society and the private sector, socio-professional associations, local representatives, sector NGOs, religious organizations and social partners.

This application takes into consideration the opinions and concerns of different affected parties and falls within the implementation of the 2009-2018 National Health Development Plan.

It uses various sector evaluations carried out over the last 3 years, completed using conclusions from the Etats Généraux (general meeting) on Immunization held in 2012. These various evaluations highlight both strengths and weaknesses of the health system that put up roadblocks to attaining strong performance as well as the MDGs.

The various facilities and resource point persons who participated in drafting this document are:

- ✓ The members of the Minister of Health's Office, the national and technical directors in the Ministry of Health and Agency Directors (ANV-PHC, ANGC, ANAM)
- ✓ Departmental Health Directors;
- ✓ partners in health development;
- ✓ members of the Health Center Management Committees;
- ✓ members of the Network of the Health-related Non-Governmental Organizations of Benin;
- ✓ members of the Association of Private, Religious and Social Organizations;
- ✓ members of the National Association of Traditional Medical Practitioners of Benin;
- ✓ members of the Order of Pharmacists;
- ✓ members of the Order of Doctors;
- ✓ members of the Association of Midwives, Nurses and Registered Nurses;
- ✓ members of the Association of Laboratory Technicians;
- ✓ social partners;
- ✓ representatives of the Ministry of Forecasting, Development and Evaluation for Public Action;
- ✓ representatives of the Ministry of the Economy and Finances;
- ✓ representatives of the Ministry of Higher Education and Scientific Research;
- ✓ representatives of the Ministry of Preschool and Primary School;
- ✓ representatives of the Ministry of Secondary Education and Vocational and Professional Training;
- ✓ representatives of the Ministry of the Environment and the Protection Nature;
- ✓ representatives of the Ministry of Foreign Affairs, African Integration, Francophone Countries and Citizens of Benin Abroad;
- ✓ representatives of the Ministry of the Family, Women and Children.

The ANV-PHC participated in the July 2013 workshops held in Ouidah and Cotonou for how to prepare and how to fill out forms

Technical assistance received during the drafting of this proposal (the source of technical assistance and feedback on the quality and usefulness of this technical assistance)

Benin has benefited from:

- ✓ support from TFPs (WHO, UNICEF, UNFPA) in Benin and support from the World Bank during the drafting of this proposal
- ✓ the presence of a WHO expert in strengthening the health system (Inter-country Support Team for West Africa) to support the national team during two technical missions (from 5 to 9 and 19 to 24 August, 2013) to finalize the application
- ✓ The support of the UNICEF BRAO consultant in charge of logistics to validate the types of refrigerators/freezers to be selected to attain Objective 2 (08/22/2013)

Global implementation process of the proposal (duration, main stages, analytical work performed, links between implementing the proposal and the planning/budgeting for the national health sector, links between implementation of the proposal)

Decisions have been made by the Steering Committee to draft the request for GAVI support to strengthen the health system created by Decree no. 3695/MS/DC/SGM/DPF/SA on 11 March 2012 (copy in appendix).

The Ad hoc Committee in charge of drafting the request benefited from the support of an international consultant made available by the World Health Organization and two national consultants.

The members of the Ad hoc Drafting Committee were divided by section according to different skill sets for data collection and analysis. The updated technical work groups contributed to several drafting workshops for different parts of the document were organized.

The Ad hoc Committee in charge of the draft met several times to ensure that work on difficult areas progressed.

Before the request is validated by the ICC, it is read and amended by the resource point persons at the national level as well as at the TFP level.

In addition, workshops were organized to approve a new GAVI format for GAV-HSS applications, but also to get the buy-in of those involved in the proposal. Among others, it involved:

- ✓ Kétou Workshop from 5 to 8 February 2013: Workshop on drafting the GAVI proposal with all participants (Government, civil society, Ministry of Health, HDD and health zones)
- ✓ Ouidah Workshop from 5 to 9 July 2013: Draft application using new form with a smaller team (ANV, DPF, HSSP, WHO along with the WHO consultant)
- ✓ Cotonou Workshop from Monday 19 to 24 July 2013: Finalizing proposal for it to be presented to the ICC
- ✓ ICC session from 3 September 2013: Amendment and validation of the two HSS requests and the PVH

Items that were the most difficult during the drafting of the proposal and the solutions found

The national team had two main difficulties, which were:

- ✓ filling out the form's sections that related to performance (particularly reference values and target values for immunization outcomes considering the poor reliability of immunization coverage data that comes from administrative data) and budgeting
- ✓ the availability of factual data to better understand the situation covered by the proposal.

These difficulties were resolved with the support of the WHO consultant from the Inter-country Team from Ouagadougou and the counselors from the country office as well as national experts.

PART E – BUDGET, GAP ANALYSIS AND WORK PLAN

11. Budget and work plan

This description will allow for the budget to be evaluated if the proposed budget sufficiently justifies the activities proposed and the costs of the activities within the framework of the HSS grant.

Please provide a budget and a detailed work plan as attachment 4 to this proposal. → It is strongly recommended that the template for the GAVI-HSS Budget, Work plan & Gap Analysis be used. In addition, the countries may also provide this information as an existing annual operational plan or equivalent document.

→Please include additional information on the applications as related to the budget and justify unit costs to show that they are reasonable and supported by planning at the national level. These applications and justifications of unit costs may be included here or attached as separate documentation.

The total budget requested from GAVI is US\$ 8,374,702 distributed over 3 objectives and including fees for managing the GAVI-HSS proposal.

Objective 1 Strengthen coverage of quality health services and specifically immunization services, and the use of health services within the two health zones targeted for implementation of results based financing totals US\$ 5,759,434 which is 69% of the total budget requested and US\$ 576,000 per year and per health zone.

- The following table shows the distribution of this budget per heading: 66% of this budget is for strengthening capacity and the competencies of those involved in the health care system within the two health zones. 7% goes to community participation. 28% of the budget is for management activities and RBF monitoring, 19% is for the operation of the external office in charge of monitoring and verifying RBF indicators, and 9% is for other monitoring activities, US\$ 66,000 of which is for logistical support that will be shared with the HDD for its supervision activities and US\$ 142,798 for performance contract with the health administration (strengthening institutional capacity for scheduling and monitoring and evaluation of RBF activities)

Objective 1 budget per heading		US\$	% tot
logistics, skills and motivation of health system participants		378 1152	66
	logistics	138,706	
	skills and motivation	3,642,446	

community involvement		388,853	7
RBF management and monitoring		158,9429	28
	external office operations	1,100,232	19
	logistical methods	66,000	
	office costs	27,243	
	other management, monitoring and communication	395,954	
TOTAL Objective 1		5,759,434	100

- It is important to specify that additional RBF-GAVI funds will be used, if received, for Objective 1, to strengthen the performance of the two targeted health zones via the RBF approach.
- We should also remember that the RBF-funded project financed by the World Bank totals US\$ 18,000,000 for 8 health zones and for 4 years or around US\$ 560,000 per year and per health zone, of which one-third is to be spent on the implementation and monitoring of the RBF.

Objective 2 "Strengthen cold chain capacity at the intermediate levels and in the two targeted health zones as well as efficient vaccine management totaling US\$ 895,555.48 or 11% of the total budget, of which a large part (76%) will allow for strengthening vaccine storage capacity at the intermediate levels and in the 2 health zones 2 (including equipment maintenance) and 24% for strengthening efficient vaccine management at all levels (including the support and distribution of immunizations by the central level to the intermediate level)

Objective 3: "Strengthen SNIGS (the National Health Information and Management System) and the use of data for M&E and strategic planning (GAVI-HSS support = US\$ 960,418.6, or 11% of the total). Around half of the funds will be used to improve the quality of NHIS data (strengthen capacity and skills of those involved, monitoring and control) and use of this data. The rest of the funds will finance surveys and studies (SARA, immunization coverage) including the final external evaluation of the program for US\$ 86,000

Management of the GAVI-HSS proposal totals US\$ 759,294.2 or 9% of the total

12. Gap Analysis & Complementarity

This description will ensure that GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication. This will also highlight the value added of the support asked of GAVI.

→ *Please complete the gap analysis tab in the GAVI-HSS Budget, Work plan & Gap Analysis Template. This Gap Analysis should be linked to each of the proposal's objectives, to clarify the total amount of resources need to strengthen the health system related to this objective, and the different funding resources from HSS that are already in place, such as those that appear on the national health sector strategy/plan, cMYP or other gap analyses that have been performed.*

→ *For each objective, the candidates will prepare the list of different HSS funding resources already in place that contribute to the proposal objective, including Government and external donors' grants, the name of the project, as applicable (or indicate budget support), the duration of the support, the funding amount provided in US Dollars and the geographic zone covered by the support.*

→ *In the box below, please describe other activities undertaken by the Government or its development partners which focus on the bottlenecks targeted by the proposed objectives, in particular, the calendar and geographic zone of the support, highlighting the value added of GAVI support and the manner in which the current proposal*

complements these activities.

The funds needed to implement RBF at the national level, strengthen the cold chain and efficient vaccine management as well as to strengthen the NHIS totals US\$ 39,549,578. The contribution expected from the national budget and other TFPs (particularly USAID, UNICEF, CTB, and WHO) is US\$ 28,136,000. Taking into account the GAVI application, there is still US\$ 3,014,876 to be sought (8% of the total) to close the gap.

Research will actively be undertaken to identify additional resources that will allow this gap to be closed. The signed national compact represents an important opportunity for this process. With the imminent arrival of Global Fund resources to implement the HSS platform, this gap could be reduced significantly.

The following table shows the distribution of TFP support for the implementation of RBF per department/health zone

Department	Health Zone	TFP RBF support			
		WB	GF	CTB	GAVIHSS
Alibori	Banikoara	1	-	-	
	Kandi-Gogounou-Ségbana	-	1	-	
	Malanville-Karimama	-	1	-	
Atacora	Kouandé-Ouassa-Péhunco-Kérou	1	-	-	
	Tanguiéta-Cobly-Matéri	-	1	-	
	Natitingou-Boukoubé-Toucountouna	-	1	-	
Atlantique	Ouidah-Kpomassè-Tori-Bossito	1	-	-	
	Allada-Toffo-Zê	-	1	-	
	Abomey-Calavi-Sô-Ava	-	1	-	
Borgou	Nikki-Kalalé-Pèrèrè	-	1	-	
	Bembèrèkè-Sinendé	-	1	-	
	Parakou-N'Dali	-	1	-	
	Tchaourou	-	-	-	1
Collines	Savè-Ouèssè	-	1	-	
	Savalou-Bantè	-	1	-	
	Dassa-Zoumè-Glazoué	-	1	-	
Couffo	Klouékanmè-Toviklin-Lalo	-	-	1	

	Aplahoué- Djakotomè- Dogbo	—	—	1	
Donga	Djougou- Copargo-Ouaké Bassila	—	—	1 - 1	
Littoral	Cotonou 6 Cotonou 5 Cotonou 2 and 3 Cotonou 1 and 4	— — — — —	1 1 1 1	- - - -	
Mono	Lokossa- Athiémè Comè-Bopa- Houéyogbé- Grand-Popo	1 —	—	- 1	
Ouémé	Adjohoun- Bonou-Dangbo Porto-Novo- Aguégués- Sèmè-Podji Avrankou- Adjarra-Akpro- Missrété	1 1 —	— — 1	- - -	
Plateau	Pobè-Kétou- Adja-Ouèrè Sakété-Ifangni	—	1	- -	1
Zou	Covè-Ouinhi- Zangnanado Bohicon- Zakpota- Zogbodomey Djidja-Abomey- Agbangnizoun	1 1 —	— — 1	- - -	
Total HZ (34)		8	9	5	2
Total budget Millions US\$ and duration of support		18 (4 years)	36 (5 years)	3,678,660 (5 years)	5.8 (5 years)

13. Viability

This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.

→ Please describe how the government is going to ensure sustainability of the results achieved by the GAVI grant after its completion. This should include the viability of funding immunization services and strengthening the health system, as well as the programmatic viability of results.

→ If there are other recurring costs included in the proposal, please describe how the country will cover these costs after support has ended.

The RBF approach is being implemented for the long-term and is to be extended to the national as a whole. Several factors encourage its longevity:

- In addition to the main objective of improving the coverage of quality health care, priority is given to high-impact health interventions and the use of these with the RBF approach; it also targets strengthening institutional capacity of the health administration, moving toward a more efficient regulated, managed health system.
- The RBF strategy goes hand in hand with the harmonization of TFP interventions (indicated by a letter of agreement, common performance indicators and a unique mechanism for managing and M&E). The RBF strategy also represents an opportunity for the implementation of the SWAp approach in Benin and more effective assistance.
- The entities, mechanisms and processes put in place for RBF to make purchasing and audit functions more effective also provide an opportunity for bringing universal health insurance to Benin (UHIP).
- The strategic document on RBF in Benin plans for strong technical assistance to be provided for RBF funds management, in particular for verification/audit functions for performance indicators. This option, if it is justified when the strategy is kicked off, would result in significant recurring costs. Attention needs to be focused on minimizing these costs in the medium term, specifically sharing the means for verification and auditing across several health zones once the institutional capacity has been strengthened and that good practice has been institutionalized.
- Implementation of the RBF approach at the national level is accompanied by strong coordination, knowledge sharing and communication about outcomes. These actions are accompanied by a strong lobbying effort that will strengthen and channel internal and external funding to the health sector. The signing of the National Compact, the establishing of a Letter of Agreement to implement the strengthening of the health system between the government and partners (World Bank, UNICEF, CTB, Global Fund and GAVI) are important steps in this direction.

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

For further instructions, please refer to the Guidelines for Completing the HSS Application

14. Implementation Strategies

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that program activities will be implemented.

Please describe:

- *how will implementation of the grant be managed; identify key implementing entities and their responsibilities with regard to governance and auditing;*
- *mechanisms which will ensure coordination among the implementing entities.*
- *financial resources from the grant proceeds that will be allocated to grant management and implementation.*
- *The role of development partners in supporting the country in grant implementation.*

Implementing entities and their responsibilities with regard to governance and auditing.

The implementation of GAVI-HSS support is under the aegis of the Ministry of Health. Implementation will be ensured by the project's Health System Strengthening Project - Coordination Unit (HSSP-CU), the entity charged with coordinating and managing Benin's entire HSS program in compliance with the terms of the Benin-GAVI Aide-Memoire signed in May 2012. HSSP-CU capacity, initially to be used to manage the HSSP project funded by the World Bank, will be strengthened by additional personnel (an accountant, an expert in RBF M&E and 2 drivers) to allow for better GAVI-HSS management. The HSSP-CU will periodically report to the CC-HSS.

All entities included in the implementation must systematically report to the HSSP-CU in compliance with the HSSP procedure manual. Through the CC-HSS, the HSSP-CU will ensure coordination of all entities included in the GAVI-HSS implementation.

The ANV-PHC will be in charge of the implementation, coordination and monitoring activities that correspond to objective 2. To do so, the ANV-PHC will create a detailed annual operational plan and budget that will be sent to the HSSP-CU for approval. The financial management of this validated operational plan will remain the responsibility of the HSSP-CU. The ANV-SSP will draft the quarterly implementation reports for activities related to the operation plan that will be sent to the HSSP-CU. An annual report will also be drafted by the ANV-SSP and sent to the HSSP-CU.

The DPF will be in charge of implementation, coordination and monitoring of activities related to Objective 3. To do so, the DPF will create a detailed annual operational plan and budget that will be sent to the HSSP-CU for approval. The financial management of this validated operational plan will remain the responsibility of the HSSP-CU. The DPF will draft the quarterly implementation reports for activities related to the operation plan that will be sent to the HSSP-CU. An annual report will also be drafted by the DPF and sent to the HSSP-CU.

The Head of the Financial Resources Division at the HDD will control financial management for the two targeted Health Zones (RBF funds) *à priori* and the internal project auditor will have *à postériori* control. Accounting documents from the Health Zone level are sent to the HSSP-CU at the national level for processing.

The outside audit firm (Zone Auditors) and the CSOs in charge of providing second-level auditing the RBF indicators are under contract with the HSSP-CU; they will carry out activities, produce inspection reports and will be paid in compliance with the contractual terms as well as with their terms and conditions.

Financial management of GAVI-HSS funds at the national level

- The Coordinator of the HSSP-CU [Health System Strengthening Project - Coordination Unit] will be

responsible for proposing expenditures along with the Terms of Reference (TORs) for activities that require fund disbursement.

- The TORs are first sent to the HSS Focal Point at WHO for technical review. If approved, the WHO-HSS Focal Point will affix a stamp of approval on the TORs and the payment order. Any TORs that are rejected will be accompanied by an explanation in writing from WHO. No activity can be authorized until it has received the WHO stamp of approval, pursuant to the provisions in this article.
- Expenditures of GAVI-HSS funds will be confirmed and authorized by the HSSP-CU Coordinator.
- The HSSP-CU Financial Management Specialist, the project accountant, will perform an *à priori* audit before implementation.
- The HSSP-CU internal auditor will perform an *à postériori* audit of expenditures after implementation.
- Payment orders for expenditures from GAVI-HSS funds are jointly signed by the HSSP-CU Coordinator and the Financial Management Specialist.
- Periodic and annual financial accounts and statements are prepared by the HSSP-CU's Financial Management Specialist. All accounting documents issued at the national and peripheral levels are transferred to this Coordination Unit for processing in the appropriate accounting software.
- Annual financial statements are submitted to GAVI at the same time as the Annual Progress Report.

Financial management of GAVI-HSS funds at the departmental level

- The Departmental Health Director is the authorizing officer for the GAVI-HSS budget. The Director proposes expenditures along with Terms of Reference (TORs) for activities that require fund disbursement.
- The Head of the Financial Resources Division at the HDD serves as the accountant for activity implementation.
- The HSS Focal Point at WHO will review the TORs and give the technical approval to conduct the activity.
- The account at the local branch of the bank where the HSS funds are held requires the signatures of both the Departmental Health Director and the Head of the Financial Resources Division at the DDS.
- e. A pre-project audit at the HDD level is conducted by the HSSP-CU Financial Management Specialist, who receives spending proposals by fax that have been approved by the HDD authorizing official and provides a written confirmation of whether the expenditure was approved or not, which is also sent by fax to the HDD. The post-audit conclusions are attached to every expenditure file and archived for future audit needs.
- The HSSP-CU Internal Auditor conducts post-HSS budget implementation audits.
- Accounting documents from the department level are sent to the HSSP-CU at the national level for processing.

Financial management of GAVI funds at the Health Zone level

- The Health Zone Coordinating Doctor (HZCD) or the Health Facility Manager, depending on the case, will be the authorizing official for the GAVI-HSS budget for the health zone or facility.
- The Administration and Resource Manager serves as the accountant for the Health Zone's GAVI-HSS budget.
- The account for HSS funds at the local bank branch or micro-finance institution will require the signatures of either the HZCD or the Health Facility Manager, and the Administration and Resource Manager for the Health Zone.
- The HDD Financial Affairs Division manager will conduct the pre-project audit and the Internal Auditor will conduct the post-project audit.
- Accounting documents from the Health Zone level are sent to the HSSP-CU at the national level for processing.

Procurement

- The national procedures contained in the manual of administrative, financial and accounting of the HSSP from the Procurement Code applicable in Benin will be used.

Internal Audit

- The internal audit will be performed by the Internal Auditor provided to the Benin HSS Program Coordination by the Technical and Financial Partners involved in HSS, and by the Ministry of Health's General Inspection in compliance with the TORs that have been transmitted to them. Copies of the internal audit reports will be transmitted to GAVI.
- The Internal Auditor will be involved in the budget implementation audits in compliance with the provisions noted in this Aide-memoire.

External Audit

- An external audit will be performed annually by an independent firm and will include all of the Benin partner

HSS programs, in compliance with the mission's joint Aide-memoire with GAVI-World Bank-Global Fund-*Coopération Technique Belge* and the WHO from 23 to 26 November 2010 that addresses harmonization between Benin HSS partners. The audit report will be communicated to the GAVI Alliance within one hundred and eighty (180) days after the fiscal year has ended.

- Therefore, the monitoring mechanisms will not only apply to evaluations, but also to both internal and external periodic audits.

→ **Coordination mechanisms between implementation entities and the role of development partners in supporting the country in grant implementation.**

- There are two types of coordination (HSS coordination committee and ICC) and an implementation entity, which is the HSSP-CU.

15. Participation of

This description will be used to assess the involvement of CSOs in the implementation of the proposed activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO².

→ *Please describe if or how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.*

→ *Please ensure that any CSO implementation details are reflected within the detailed budget and work plan.*

In Benin, numerous international and national Non-governmental organizations (NGOs) are active in the health sector. They can be found in areas that cover the mobilization of resources, supply and demand of care-related services, social mobilization, advocacy, governance and monitoring and evaluation. They are also involved in developing sector- and subsector- specific strategies.

Nationally, for example, some NGOs, in an effort to yield greater influence, have created a network called the Benin NGO Health Network [*Réseau des ONG Béninoises de Santé*], or ROBS. There is also the Association of Private, Religious and Social and Associative Organizations [*Association des Œuvres Médicales Privées, Médicales Privées, Confessionnelles, Associatives et Sociales*], or AMCES. They have national headquarters and offices at the departmental level.

As part of their cooperation with the Ministry of Health stakeholders, the Civil Society Organizations (CSOs) are members of the National Committee for Monitoring Project/Program Performance and Evaluation (CNEEP), the ICC, the National Committee for Coordinating Projects funded by the Global Fund (CNC). And, lastly, it must be noted that many CSOs are members of community management committees for health centers (COGEC).

The Civil Society Organizations (CSOs) will be involved in the implementation of monitoring and evaluation at several levels and within several different areas.

CSOs will be involved in HSS Coordination Committee decisions. Approval by the GAVI-HSS Annual Work Plans and monitoring the programmatic and financial implementation; monitoring the attainment of targets (indicators for intermediate outcomes, immunizations and impact), approval of progress reports, etc.

With regard to the implementation of RBF in the two targeted health zones, the HSSP-CU will have a contract four Community-Based Organizations (2 per health zone) to ensure that there is a second level audit of the quantitative and qualitative RBF indicators. These CSOs mission will include:

- Carrying out second-level auditing of RBF quantitative RBF health care services at the community level on a

²In special circumstances, GAVI can transfer funds directly to a CSO. Please refer to the application Guidelines for further information.

quarterly basis.

- On a bi-annual basis, carry out an evaluation of quality as perceived by the population, using sampling at community health facilities.

During the 2014-2018 period, the GAVI-HSS funds that will be allocated to the 4 Community-Based Organizations for this second-level auditing assignment totals US\$ 372,443.

The CSOs will also have an important role in implementing health actions at the community level (community activity packages, including promoting immunization, active research on dropouts) in the two health zones targeted for RBF funding.

16. Technical Assistance

This description will outline to GAVI how technical assistance will support implementation of the proposed activities.

→ Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and immunization program function.

→ Please outline how technical assistance will improve institutional capacities of government agencies and CSOs and contribute to sustainability.

Technical assistance included in the application and its impact on the immunization program

- HSSP-CU recruitment of an outside firm to be in charge of auditing RBF indicators in the two health zones (2 technical assistants per zone, 2 additional auditors)
- Recruitment by CU-PSHSP of a consultant to implement the RBF portal site for health facilities in the two health zones
- HSSP-CU recruitment of a national consultant specialized in procurement, to train participants
- Technical support from the WHO in drafting the annual DQRC and carrying out a SARA survey every two years (2015 and 2017)
- Technical support from UNICEF to strengthen the national capacity to install positive cold rooms
- Technical support from the WHO and UNICEF to evaluate immunization management efficiency in 2015
- Technical support from the WHO and UNICEF to carry out a survey on immunization coverage in 2018
- Supreme Court recruitment of an outside auditing firm to audit and certify the actions taken, including immunization activities
- HSSP-CU recruitment of an international firm to conduct a final external evaluation of GAVI-HSS, scheduled for the fifth year (2018).

Technical assistance and its impact on institutional capacities of government entities and CSOs and

contributions to sustainability..

All technical assistance takes place to strengthen the Ministry of Health's institutional capacities and to make interventions sustainable by transferring skills to those involved throughout the country.

<p><i>Institutional Risks:</i></p> <ol style="list-style-type: none"> 1. RBF is relatively new in Benin. The long-term foothold that RBF has in Benin's institutions remains to be seen, in relation to continued decentralization within the health system 2. The full support of certain TFPs for the RBF strategy is not yet a given 3. Availability of human resources within the health system: 	<p><i>Weak</i></p> <p><i>Weak</i></p> <p><i>Medium</i></p>	<p><i>Weak</i></p> <p><i>Weak</i></p> <p><i>Medium</i></p>	<ol style="list-style-type: none"> 1. The project team has learned several lessons from the experience of the 2007 pilot phase as well as that of other countries. The focus was, then, on communication and training efforts, not only at the national level, but also at the local level (health workers and communities) 2. RBF counts on wide dissemination of the outcomes attained in the 8 zones financed by the World Bank and community verification by UNICEF as well as actions supported by the CTB 3. The human resources health recruitment plan for 2012-2014 was adopted by the Government in 2012 and will allow for 1,218 health workers to be recruited in 2013. The RBF approach will, in essence, provide intrinsic and extrinsic motivation for health personnel and will, therefore, directly encourage the attraction and retention of such personnel within health care structure. Benin's RBF plans for bonuses to be given to the HDD and HZMT using performance indicators, one of which is linked to the availability of health personnel in the health facilities. The last point encourages assigning/deployment of health personnel per required norms.
<p><i>Operational Risks:</i></p> <ol style="list-style-type: none"> 1. There is a risk that health workers will manipulate (inflate) outcome indicators to increase their RBF credits 	<p><i>Medium</i></p>	<p><i>Medium</i></p>	<ol style="list-style-type: none"> 1. This risk has been anticipated and mitigated by the following factors: a) the separation of out payment, auditing/second-level auditing, regulatory and service functions, b) the contracts that exist with the health facilities, c) the audit mechanisms that are in place and d) established sanction mechanisms. Twice per quarter, the (independent) zone auditors audit each health facility for consistency between the qualitative indicator data reported and the data listed in source records. The Community-Based Organizations under contract will conduct second-level audits at the community level on a quarterly basis; their goal is to verify the quality of the data being reported in the source

			records. Qualitative indicators will be audited on a bi-annual basis by external (independent) auditors and by the CBO (second-level audits) using random sampling of health facilities
Overall Risk Rating for Objective 1	Weak	Medium	
Objective 2: Strengthen cold chain capacity at the intermediate level and within the two targeted health zones as well as increase in efficient vaccination management			
Fiduciary Risks:	<i>none</i>	<i>none</i>	Procurement through UNICEF
Institutional Risks:	<i>none</i>	<i>none</i>	
Operational Risks:			
1. long delivery delays and equipment installation	Weak	Medium	1. Cold chain equipment will be purchased through UNICEF's procurement division. The country has planned for a delivery time of 6 months. Use of 2 cold rooms will be guaranteed by the national section with the support of UNICEF specialists.
2. Quantitative and qualitative lack of personnel in charge of EPI at decentralized levels	Medium	Medium	2. The National Human Resource Development Plan in Benin foresees strengthening health personnel capacity in the short- and medium- terms
3. Lack of service capacity nationally to provide maintenance for the solar cold chain	Weak	Medium	3. Companies will be selected using recognized qualifications and the NV-PHC will ensure that their activities will be closely monitored
Overall Risk Rating for Objective 2	Weak	Medium	
Objective 3: Strengthen SNIGS and the use of data for monitoring and evaluation and strategic planning			
Fiduciary Risks:	<i>none</i>	<i>none</i>	
Institutional Risks:	Weak	Weak	1. The GAVI-HSS support requires technical support to carry out these activities

1. Certain activities (SARA, DQRC, etc.) require national technical expertise that still needs to be strengthened			
Operational Risks:			
1. Risk of under- or over-reporting of health information data	Medium	Weak	1. This has been minimized by strengthening SNIGS quality control and making participants responsible
2. Quantitative and qualitative lack of personnel in charge of SNIGS at decentralized levels	Medium	Medium	2. The National Human Resource Development Plan in Benin foresees strengthening health personnel capacity in the short- and medium- terms
Overall Risk Rating for Objective 3	Weak	Medium	
<i>Please add more rows for additional objectives...</i>			
TWO PAGES MAXIMUM			

18. Financial Management and Procurement Arrangements

In this section applicants are requested to describe:

→ a) The proposed financial management mechanism for this proposal;

→ b) The proposed processes and systems for ensuring effective financial management of this proposal, including the organization and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow), procurement, accounting and financial reporting (incl. fixed asset management), internal control and internal audit, and external audit. CSOs can receive GAVI funding through two channels: (i) GAVI sends funds to the Ministry of Health which then transfers them to the CSO, or (ii) GAVI sends funds directly from GAVI to the CSO. Please refer to Annex 4 of the Guidelines for further details;

→ c) The main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfill the above functions

4 pages maximum (additional pages will be required if there is more than one main implementing entity)

Question A: applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one.

The manual of administrative, financial and accounting program defines the roles, responsibilities and tasks of all members of UC-HSSP who have responsibilities for the implementation of the program and, therefore, the application submitted to Global Fund. The Coordination Unit has two (2) categories for key personnel. The first category, recruited with competitive exams, who are subject to a work contract that describes the tasks to be performed within the program (specifications) and a second category made up of workers whose positions are made available by Ministerial Decree, specifying open positions.

In addition, it should be noted the RBF Strategic Document addresses the separation of functions, the HSS Coordination Committee decree standardizes and the HSSP manual of administrative, financial and accounting procedures formalizes the main procedures for HSSP administrative, financial and accounting management. Its objectives are:

- ✓ *train a specific group within the personnel to implement operations,*
- ✓ *describe administrative, financial and accounting organization,*
- ✓ *describe the implementation procedures for expenditures in conditions that will guarantee efficient internal control,*
- ✓ *formalize the audits to be conducted,*
- ✓ *guarantee transparent and consistent operations,*
- ✓ *serve as a reference for operational tasks,*
- ✓ *describe the procedures to be put into place by different participants who are involved in the Program's implementation (account administrative, financial and technical HSS Program*

	<p><i>personnel as well as the personnel of other partners) as well as the tasks for which they are responsible,</i></p> <ul style="list-style-type: none"> ✓ <i>use all available means for a most efficient implementation, including human resources, equipment and financial support.</i> <p>The manual is structured so that it is easy to use and easy to update so that it can be adapted as needed as the organization of the HSS Program evolves and procedures are formalized. The manual has eight sections:</p> <ul style="list-style-type: none"> ✓ <i>Introduction to the manual,</i> ✓ <i>Introduction to the Health System Strengthening (HSS Program),</i> ✓ <i>Administrative procedures,</i> ✓ <i>Procurement procedures,</i> ✓ <i>Financial procedures,</i> ✓ <i>Budget procedures,</i> ✓ <i>Accounting procedures,</i> ✓ <i>Monitoring and evaluation procedures.</i>
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Question B: Financial Management Arrangements Data Sheet

All beneficiaries (organization/country) applying to receive direct financing from GAVI must complete this information sheet (for example the Ministry of Health and/or a CSO that receives direct financing).

<p>1. <i>General information to be provided by the recipient organization/country.</i></p>	<p>National Coordinator for the Coordination Unit within the Health Strengthening System Program (HSSP)</p> <p>Alphonse Akpamoli</p> <p>01 BP 1941 Cotonou Benin</p> <p>Telephone: + (229) 21 31 52 08/21 31 52 17 / 97 22 03 71</p>
<p>2. <i>Has the recipient organization already worked with GAVI, the World Bank, WHO, UNICEF, or the Global Fund for the prevention of AIDS, tuberculosis and malaria or other development partners and has it already received grants?</i></p>	<p style="text-align: center;">YES</p>
<p>3. If YES</p> <ul style="list-style-type: none"> • <i>Please provide the name and amount of the grant, as well as the years awarded.</i> • For completed GAVI grants and other development partners: please briefly describe the main conclusions related to the use of 	<p>GAVI: US\$ 886,500 (2013)</p> <p>World Bank US\$ 44.8 million (2012-2015)</p> <p>Since 2011</p> <p>Management problems: APR</p>

<p><i>these funds from a financial management outcome.</i></p> <ul style="list-style-type: none"> • For ongoing GAVI grants and other development partners: <i>please briefly describe any financial management or procurement problems (for example, ineligible expenses, out-of-the-norm purchases, misuse of funds, late account audit reports, and account audits that showed reserves).</i> 	
<p>Oversight, Planning and Budgeting</p>	
<p>4. <i>Which entity will be responsible for in-country oversight of the program? Please briefly describe membership, meeting frequency as well as decision making process.</i></p>	<p>The Coordination Committee for Health System Strengthening (HSS-CC) was created by decree in 2011 n°1119/MS/DC/SGM/SA (Creation, Attribution and Operation of the Coordination Committee for Health Service Strengthening). This Committee is responsible for supervising all HSS activities, and specifically (Article 3 of the Decree):</p> <ul style="list-style-type: none"> ✓ to assess the progress made by the HSS and to ensure consistency with national objectives; ✓ to approve the HSS annual activity plans; ✓ to approve possible adjustments or modifications to ensure proper implementation of the HSS; ✓ to make recommendations to the various parties involved in implementing the Program and recommendations on reaching their objectives; ✓ to, at any time, initiate technical evaluation missions or financial audits for the HSS. <p>HSSP-CU participates in CCM meeting on the proposal and all technical meetings related to its preparation.</p> <p>The coordination HSS Global Fund support with the other participants will include organizing:</p> <ul style="list-style-type: none"> ✓ quarterly meetings with all participants, co-chaired by the lead Partner and the Minister of Health to discuss the consistency and relevance of interventions in relation to the (RBF) sector strategy and to monitor the work plan, ✓ bi-monthly meetings by the development partners' technical health group within the health sector; ✓ annual sector reviews to evaluate the implementation of all interventions and to decide on future strategies needed to improve performance; ✓ regular and extraordinary HSS and CNEEP steering committee meetings will be organized as needed. <p>Discussions are scheduled for assessing the RBF within the Technical Group created within the Ministry.</p>
<p>5. <i>Who will be responsible for annual GAVI-HSS planning and budgeting?</i></p>	<p>Coordination Unit within the Health Strengthening System Program under the supervision of the Directorate of Planning and Forecasting within the Ministry of Health</p>
<p>6. <i>What is the planning & budgeting process and who is responsible for approving the annual GAVI-HSS work plan and budget?</i></p>	<p>The TORs are first sent to the HSS Focal Point at WHO for technical review. If approved, the WHO-HSS Focal Point will affix a stamp of approval on the TORs and the payment order. Any TORs that are</p>

	<p>rejected will be accompanied by an explanation in writing from WHO. No activity can be authorized until it has received the WHO stamp of approval, pursuant to the provisions in this article.</p> <p>Expenditures of GAVI-HSS funds will be confirmed and authorized by the HSSP-CU Coordinator.</p>
7. Will the GAVI HSS program be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement (for example, SWAp, budget support or pooled funding)? Please provide the list of the authorized signatories for the release of funds and all requests for additional funds.	<p>Amount: in FCFA</p> <p>Authorized signatures:</p> <ul style="list-style-type: none"> ✓ National HSSP Coordinator ✓ HSSP Financial Management Specialist
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?	Fonds transferred to a commercial bank: Bank of Africa BENIN (Cotonou - BENIN) in the name of Benin/GAVI HSS Program
10. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors - a "pooled account")?	The Account will only be funded with GAVI funds the other partners will have separate accounts
11. Within the HSS program, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled.	<p>YES</p> <ul style="list-style-type: none"> - Funds targeted for HSS activities at the departmental level and in the Health Zones will be transferred into the accounts opened at local branches of the commercial bank for the purpose of receiving GAVI funds. In the event that a Health Zone does not have a bank branch for the main bank, a bank account will be opened in the local branch of another bank or in a micro finance institution, chosen and guaranteed as reliable by the Ministry of Health and the Ministry of Finances. - Expenditures of GAVI-HSS funds will be confirmed and authorized by the HSSP-CU Coordinator. - The HSSP-CU Financial Management Specialist, the project accountant, will perform an <i>à priori</i> audit before implementation. The HSSP-CU internal auditor will perform an <i>à postérieur</i> audit of expenditures after implementation. - Payment orders for expenditures from GAVI-HSS funds are jointly signed by the HSSP-CU Coordinator and the Financial Management Specialist. - The Departmental Health Director is the authorizing officer for the GAVI-HSS budget. The Director proposes expenditures along with

	<p>Terms of Reference (TORs) for activities that require fund disbursement.</p> <ul style="list-style-type: none"> - The Head of the Financial Resources Division at the HDD serves as the accountant for activity implementation. - The HSS Focal Point at WHO will review the TORs and give the technical approval to conduct the activity. - The account at the local branch of the bank where the HSS funds are held requires the signatures of both the Departmental Health Director and the Head of the Financial Resources Division at the DDS. - e. A pre-project audit at the HDD level is conducted by the HSSP-CU Financial Management Specialist, who receives spending proposals by fax that have been approved by the HDD authorizing official and provides a written confirmation of whether the expenditure was approved or not, which is also sent by fax to the HDD. The post-audit conclusions are attached to every expenditure file and archived for future audit needs. - The HSSP-CU Internal Auditor conducts post-HSS budget implementation audits. - Accounting documents from the department level are sent to the HSSP-CU at the national level for processing. - Periodic and annual financial accounts and statements are prepared by the HSSP-CU's Financial Management Specialist. All accounting documents issued at the national and peripheral levels are transferred to this Coordination Unit for processing in the appropriate accounting software. - Annual financial statements will be submitted to GAVI at the same times as the annual progress report
Procurement	
<p><i>i. What procurement system will be used for the GAVI-HSS Program? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)</i></p>	<ul style="list-style-type: none"> - Procurement procedures for all program goods and services are described in the procedure manual. All phases of all procedures must be documented. The World Bank's procurement guidelines and document types will be used for the Program's procurement. The Project is to develop an annual procurement plan that contains all contracts to be bid along with the method used for each. This plan must be approved by the proper authorities and updates as needed. - The beneficiaries of good or services are to develop technical specifications for goods or TORs for services to be acquired and provide them to the Program. The Program directs the remainder of the procedure to be followed: drafting bid packets, sending out calls for bid, receiving and evaluating bids, signing contracts for collaboration with the beneficiaries. The non-objection of the proper authorities is to be obtained at each required stage - The national procedures contained in the manual of administrative, financial and accounting of the HSSP from the Procurement Code applicable in Benin will be used.
<p><i>12. Do you plan to procure certain items through GAVI's system in-country partners (UNICEF, WHO)?</i></p>	<p>Yes, the procedure with UNICEF is going for the cold chain equipment being funded by GAVI</p>
<p><i>13. What is the staffing arrangement of the organization in procurement?</i></p>	<p>Call for proposals</p>

<p>14. Are there procedures in place for the physical inspection and quality control of goods, works, or services delivered?</p>	<p>YES</p>
<p>15. Is there a functioning complaint mechanism? Please describe.</p>	<p>YES, the procurement procedures to be used are described in the Project procedure manual approved by the World Bank in accordance with World Bank guidelines. The manual include all of the methods to be used, procedures for sending out and evaluating bids. Provisions related to conflicts of interest have also been addressed.</p>
<p>16. Are efficient contractual dispute resolution procedures in place? Please describe.</p>	<p>YES, the provisions related to conflicts of interest have also been addressed in the manual.</p>
<p>Accounting and financial reporting (incl. fixed asset management)</p>	
<p>17. What is the staffing arrangement for the organization of accounting and reporting?</p>	<p>The HSSP has a financial staff qualified to implement the program. The staff includes a financial management specialist with sufficient skills and experience to implement the Program's activities</p> <p>The accountant will assist the Financial Management Specialist and recruiting for the accountant is underway, subject to funding from the World Bank. The Financial Management Specialist is in charge of the finance and accounting department.</p> <p>It has been determined that there will be an Accountant to assist the Financial Management Specialist. Recruiting for this Account is currently ongoing and only in need of a signature.</p>
<p>18. What accounting system will be used for the GAVI-HSS Program? (Is there a specific accounting software or a manual accounting system?)</p>	<p>The manual of administrative, financial and accounting procedures for the Health Strengthening System Program (HSSP) describes the Program's accounting and finance system and clearly defines the roles/responsibilities of the different participants and the rule on the separation of powers.</p> <p>The accounting and finance system is computerized and operations using the project management software called "SUCCESS". The "SUCCESS" software has the following modules:</p> <ul style="list-style-type: none"> - Integrated general accounting, analytical budget module; - Procurement module; - Equipment management modules; - Funds disbursement module; - Payment module; - Financial reporting module; - Inventory management module and Fleet module which have not yet been activated. <p>The "SUCCESS" software assists in maintaining multi-funded, multi-project and multi-donor accounting.</p>

<p>19. How often does the implementing entity produce interim financial reports and to whom are those submitted?</p>	<p>The reports below are produced on the World Bank funding currently being implemented by the HSSP-CU:</p> <ul style="list-style-type: none"> - A quarterly finance report - A bi-annual report on project implementation and an annual progress report. - These reports produced within deadline have always been considered to be of good quality by the World Bank. <p>The budgets are specific to each funding project. They are then consolidated and submitted to the partners to avoid duplication.</p>
<p>Internal control and internal audit</p>	
<p>20. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?</p>	<p>YES</p>
<p>21. Does an internal audit department exist within recipient organization? If yes, please describe how this department will be involved in GAVI-HSS.</p>	<p style="text-align: center;">YES</p> <p>The internal audit will be performed by the Internal Auditor provided to the Benin HSS Program Coordination by the Technical and Financial Partners involved in HSS, and by the Ministry of Health's General Inspection in compliance with the TORs that have been transmitted to them. Copies of the internal audit reports will be transmitted to GAVI.</p>
<p>22. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?</p>	<p>YES</p>
<p>External audit of accounts</p>	
<p>23. Will the annual financial statements be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?³</p>	<p>An external audit will be performed annually by an independent firm and will include all of the Benin partner HSS programs, in compliance with the mission's joint Aide-memoire with GAVI-World Bank-Global Fund-Coopération Technique Belge and the WHO from 23 to 26 November 2010 that addresses harmonization between Benin HSS partners. The audit report will be communicated to the GAVI Alliance within one hundred and eighty (180) days after the fiscal year has ended.</p>
<p>24. Who is responsible for the implementation of audit recommendations?</p>	<p>Coordination Unit within the Health Strengthening System Program (HSSP-CU)</p>
<p>THREE PAGES MAXIMUM</p>	
<p><i>Question C: Please indicate the main constraints present in the (health sector's) financial management system. Does the country plan to address these constraints/issues? If so, please describe the Technical Assistance (TA) needs in order to fulfill the above functions</i></p> <p>The financial management system constraints are:</p>	

³If the annual external audit is to be performed by a private, outside auditor, please include an appropriate audit fee within the detailed budget.

- *Insufficient resources allocated in the national budget*
- *Progressive reduction of external financial support*
- *Lack of procedure manuals in several facilities within the health pyramid*
- *Lack of operational links that are clearly defined between the Directorate of Financial and Material Resources (DRFM) and intermediate and peripheral financial entities*
- *The need to strengthen the means of implementing material accounting*
- *The complexity of procedures for certain purchases, such as those for reagents, immunizations, etc.*
- *The country plans to address the issues mentioned above using technical assistance to:*
- *Draft procedural financial and accounting manuals to benefit the relevant facilities*
- *Define the operational links between Administration and Resource Managers (CAR), Senior Managers from Financial and Material Resource Services (C/SRFM), Senior Managers from Financial Affairs (C/SAF) and from Directorate of Financial and Material Resources (DRFM) to provide improved centralization of data for an optimized decision-making process*
- *Install material accounting software and related tools*
- *Implement a more streamlined procedure for the acquisition of reagents, anti-retrovirals (ARV), in compliance with the relevant decree*

Until this process for strengthening the financial management is implemented, the procedure manuals developed for the World Bank's PRPRSS project will be used in the two targeted health zones.

HALF OF A PAGE MAXIMUM

SUMMARY OF A COMPLETE APPLICATION

HSS Proposal Forms and Mandatory GAVI attachments

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
1.	HSS Proposal Form	
2.	Signature Sheet for Ministry of Health, Ministry of Finance and HSCC members	
3.	HSS Monitoring & Evaluation Framework	
4.	Detailed work plan and detailed budget	

Existing National Documents - Mandatory Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ Please place an 'X' in the box when the attachment is included

No.	Attachment	X
5.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	
6.	National M&E Plan (for the health sector/strategy)	
7.	National immunization plan	
8.	National cMYP	
9.	Vaccine assessments (EVM, post-introduction assessment, EPI reviews), if available	
10.	Health Sector Coordinating Committee Mandate (HSCC)	

Existing National Documents - Additional Attachments

Where possible, please attach approved national documents rather than drafts. For a highly decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.

→ → *Please place an 'X' in the box when the attachment is included*

No.	Attachment	X
1.	Joint Assessment of National Health Strategy (if available)	
2.	Response to Joint Assessment of National Health Strategy (if available)	
3.	If funds transfers are to go directly to a CSO or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent outside auditor	
...		

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