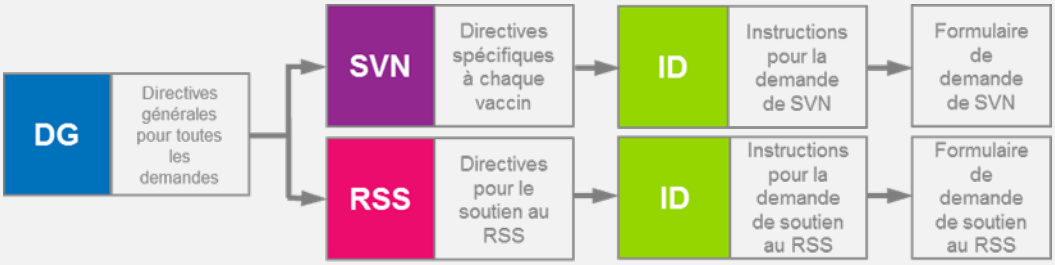
Application Form:
Health System Strengthening Support (HSS) in 2016

Deadline for submission of application:
1 September 2016

Document date: October 2015
(This document replaces all previous versions)

Application documents for 2016:

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



Application Form:

Purpose of this document:

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

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

Weblinks and contact information:

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

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PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	*This should correspond exactly to the budget requested in Question 17 (detailed budget):* ***3,496,529.1***	
Does your country have a finalised and approved National Health Development Plan?	Yes ☒	No ☐
	*Indicate the **2020** NHDP **end year*** ***Provide Mandatory Attachment no. 8: NHDP***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes ☒	No ☐
	Indicate the **2020** cMYP **end year** *Provide Mandatory Attachment no. 11: cMYP*	
Proposed HSS grant start date:	Indicate the month and year of the grant's planned start date. **October 2017**	
Proposed HSS grant end date:	*Indicate the month and year of the planned end date of the grant.* **September 2022**	
Joint appraisal planning:	*Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.* **4th quarter of each year / Sector steering committee chaired by the Ministry of Health's General Secretariat**	

2. Application development process (2-page maximum)

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

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

no. 4: *Minutes from HSCC meeting at which the HSS application was endorsed;*

no. 5: *Minutes from last 3 HSCC meetings; and*

no. 15: *HSCC ToRs*

In October 2015, Mauritania expressed interest to Gavi about receiving a second round of support for health system strengthening for its immunisation programme.
In the interest of efficiency, Gavi recommended that the government first use any funds remaining from the previous HSS1 grant as part of this budget allowance reprogramming. The reprogramming was drafted and submitted on 30 May 2016 for the 1 September 2016 to 31 August 2017 period.
After a request was submitted to use the remaining HSS1 funds for reprogramming, the HSS2 application was begun.

Within this framework, a technical committee was created per Service Note no. 59 on 7 April 2016. This committee is chaired by the Ministry of Health's Director of Planning, Cooperation and Health Information (DPCIS/MH) and it was created to prepare the HSS2 application.

To encourage the participation of all those involved with immunisation, the technical team responsible for drafting the proposal brings together representatives from the Ministry of Health's central departments (DPCIS, DSBN, etc.), the EPI, the FTPs (WHO and UNICEF), and the CSOs. It was noted that wilaya and moughataa representatives were not physically present for financial reasons, but they were included via telephone so that they had required information as needed.
The EPI is one of the main entities who actively participated in formulating the proposal. The EPI's participation contributes to the removal of bottlenecks that prevent reaching expected health outcomes.

The Ministry of Health requested technical assistance from a UNICEF subject matter expert to help draft the application for health system strengthening. This request was approved and an expert enabled the team to fill out the application form for Gavi health system strengthening support and to respond to the questions raised during the WHO pre-review.

The main stages of developing the proposal can be summarised as follows:

- endorsement of the expression of interest by the sector steering committee;
- creation of a technical committee responsible for developing the proposal using Service Note no. 59 from 7 April 2016.
- technical committee work meetings with the consultant were held in May 2016 and then again from July to September 2016 to focus on document improvements;
- endorsement of the proposal by the national steering committee for the health sector (NSC-HS) too place on 23 August 2016;
- endorsement of the proposal by the ICC on 25 August 2016;

The CSOs actively participated in proposal development through the quality of the technical committee members from the ICC and NSC-HS involved in preparing the application (see list of participants and workshop minutes as an attachment).

They are:

- Volunteer Action Network (VACNET)

- Mauritanian Public Health Association (AMSP)

- Mauritanian for Assisting Ill Indigents (AMAMI)

- Doctors of the World - Mauritania

- National Association for Local Participative Development (ANADELP)

WHO and UNICEF have actively participated in the process by providing technical and financial input.

Development of the proposal fits with the priorities and strategies of the 2012-2020 NHDP and the 2016-2020 cMYP.

3. Signatures

3a. Government endorsement

*Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment no. 2**.*

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

The Minister of Health (or delegate)

Name: Professor Kane Boubacar

Signature:

Date:

The Minister of Economy and Finance (or delegate)

Name: MoctarOuldDjay

Signature:

Date:

3b. Health Sector Coordinating Committee (HSCC) endorsement

*Include HSCC official endorsement of the HSS proposal – **Mandatory Attachment no. 3***

Include a signature of each committee member in attendance and date.

***Mandatory Attachment no. 3*: HSCC Endorsement of HSS Proposal**

*We the members of the HSCC, or equivalent committee, met on **23 August 2016** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.*

Please list all HSCC members	Title/Organisation	Name	Sign below to confirm:	
			Attendance at the meeting where the proposal was endorsed	Endorsement of the minutes where the proposal was discussed
Chair				
Secretary				
MH members				
Development partners				
CSO members				
WHO				
UNICEF				
Others				

4. Analytical summary *(2-page maximum)*

Provide an executive summary of the application.

Mauritania's health sector has a 2012-2020 National Health Development Plan (NHDP) that contains a health programme implementation strategy. The objectives and actions related to strengthening immunisation coverage and the introduction of new vaccines are included in the 2012-2020 National Health Development Plan (NHDP) along with high-impact initiatives for reducing mortality in children under-five.

This was the basis for the country developing a new comprehensive Multi-Year Plan (cMYP) for 2016-2020 that would better channel activities and make progress in the immunisation of various populations and, specifically, children.

Governance and steering of Mauritania's health sector are via the National Steering Committee for the Health Sector (NSC-HS) and also via the Inter-agency Coordinating Committee (ICC) for Immunisation and the Multisectoral Coordination Committee for Grants from the Global Fund.

In 2014, at the national level, the geographic accessibility rate was 80% (NHIS), the curative service use rate was 42.78% and the penta3 coverage rate was 81.2% (2016-2020 cMYP).

Despite an acceptable doctor ratio (1.9/10,000 residents) an acceptable midwife ration (0.8/5,000 residents), significant inequalities still exist in how staff is distributed throughout the country's various regions. There is a notable concentration of staff in the capital. Inadequate career management is a significant source of the lack of motivation that exists. The process of involving communities and civil society organisations in health service management and the services being offered is still a work in progress.

Procuring pharmaceutical products for the public sector is the responsibility of Central Purchasing for Essential Drugs and Medical Supplies - CAMEC (*Centrale d'Achat des Médicaments Essentiels et Consommables*). Certain health programmes receive supplies directly from United Nations agencies, for example, the procurement of vaccines from UNICEF within the framework of the vaccine independence initiative.

According to the 2016 SARA survey data, the availability of essential drugs is inadequate at a rate of 26%. The effective vaccine management (EVM) assessment conducted in 2014 revealed inadequate storage capacities at the intermediary and peripheral levels.

In 2015, the MH's portion of the General State Budget was 4.6%. The 2013 national health accounts show that households bear more than 40% of the country's health expenditures. At-risk group's difficult financial access to healthcare negatively affects the healthcare system in general as well as specifically affecting the immunisation programme.

The national health information system suffers from being fragmented and from poor quality data.

The NHIS is expected to improve with the implementation of a new system, the District Health Information System 2 (DHIS 2), in conjunction with mapped geographic reference data for services being provided.

The ability to achieve sector objectives is limited by various constraints that also affect immunisation outcomes. These constraints are consistent with the bottlenecks mentioned in the 2016-2020 EPI cMYP.

The overall objective of the Gavi/HSS application is to contribute to integrated health system strengthening to ensure equitable immunisation coverage. The following bottlenecks will be prioritised: (i) human resources that are both quantitatively and qualitatively inadequate at the national and regional levels. This is to be addressed by implementing a sustainable strategy to build capacity and to provide service providers with continuous training on public health and curative care. The goal of this is to provide attractive, high-quality health and immunisation activities, (ii) the lack of equity in geographic and financial accessibility to quality health services, and specifically immunisation services. This mainly affects populations found in peripheral rural areas, nomadic populations and populations found in

remote areas, (iii) weaknesses present in effective vaccine management and effective immunisation input management, specifically with regards to maintenance and including the availability of essential drugs at both the national and regional levels, (iv) the lack of mechanisms and tools for governance at the national and regional levels interferes with coordinating and planning initiatives within the sector, accessing target populations and distribution, and community involvement in health system management—specifically in immunisation management, (v) both the regional and operational levels have inadequate information systems for documentation, archiving, health system research, knowledge management, and, specifically, for immunisation data management, (vi) an inadequately implemented strategic community approach for complementary healthcare services and lack of a consistent and effective communication efforts that focuses on social and behavioural change.

Initiatives included in the Gavi/HSS2 application will consolidate gains made as a result of previous support (Gavi/HSS1 and HSS1 Reprogramming). Gavi/HSS2 initiatives are complementary with those of the other FTPs and the government.

They will be implemented in 23 of the country's 55 moughataas who were selected using the following approach:

- Moughataas who benefited from the previous grant were among those selected. Nine moughataas were chosen using this important factor so as to capitalise on the gains made during HSS1,
- From among those with lower-than-average immunisation coverage (74%), 14 other moughataas were also selected using the following criteria: penta3 coverage levels, dropout rates, demographic weight and geographic coverage rates.

In 2016, these moughataas have a population of 1,450,777 residents and are served by 377 health facilities (HOs, HCs and hospitals).

The planned initiatives are broken out into the five following strategic objectives:

1. **by September 2022, at the national level, strengthen the availability of competent human resources in the ZCIs and coordinating entities**: US$ 1,261,411
2. **by September 2022, improve community participation and financial and technical transparency within the ZCI health systems**: US$ 269,640
3. **by September 2022, in the ZCIs, strengthen basic health service coverage including immunisation, using the RED approach**: US$ 925,604
4. **by September 2022, increase the use of health services by stimulating demand**: US$ 501,804
5. **by September 2022, strengthen monitoring and evaluation and epidemiological surveillance capacity in the ZCIs and at the national level**: US$ 510,594

The total amount of Gavi's support over a five-year period from October 2017 to September 2022 will be US$ 3,469,053.

The Ministry of Health will be responsible for implementing and administering the Gavi/HSS grant. The process will involve the participation of various entities and/or national organisations as well as the national, intermediary and peripheral levels, and the CSOs and CBOs. The two latter will execute various promotional and social mobilisation activities.

Administrative and financial grant management will be conducted according to the Ministry of Health's management procedures.

Progress will be monitored and evaluated using indicators garnered from routine NHIS data, from programme and financial activity implementation reports, from the various levels of programme implementation, and from factual data found in surveys, studies and evaluations.

5. Acronyms

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

Acronym	Acronym meaning
RED	Reach Every District
AFD	French Development Agency - *Agence Française de Développement*
CHW	Community Health Worker
WB	World Bank
CAMEC	Central Purchasing for Essential Drugs and Medical Supplies - *Centrale d'Achat des Médicaments Essentiels*
KAP	Knowledge, Attitudes and Practice
ICC	Inter-agency Coordination Committee
CC	Cold chain
MTEF	Medium-Term Expenditure Framework
CDSS	Council for Socio-health Development - *Conseil de Développement Socio-Sanitaire*
CDDSS	Departmental Council for Socio-health Development - *Conseil Départemental de Développement Socio-Sanitaire*
IPC	Interpersonal communication
MC	Management Committee
HC	Health Centres
CSM	Moughataa Health District
TC	Technical Committee
IC	Immunisation Coverage
DAF	Financial Affairs Directorate
DHIS 2	District Health Information Software 2
DIMM	Infrastructure, Equipment and Maintenance Directorate
DCD	Disease Control Directorate
DPCIS	Planning, Cooperation and Health Information Directorate - *Direction de la Programmation, de la Coopération et de l'Information Sanitaire*
PHE	Public Health Expenditure
DRAS	Regional Health Action Directorate - *Direction Régionale à l'Action Sanitaire*
HRD	Human Resources Directorate
DSBN	Basic Healthcare and Nutrition Directorate

DTP	Diphtheria, Tetanus, and Pertussis vaccine
DHS	Demographic and Health Survey for Mauritania
EPCV	Survey of Household Living Conditions - *Enquête sur les Conditions de Vie des Ménages*
HE	Health Education
RBF	Results-Based Funding
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
FOSA	Health Facility - *Formation Sanitaire*
Gavi	The Gavi Alliance
EVM	Effective Vaccine Management
PSDSS	Head of Mission Nurse
IDE	Nurse with State Diploma - *Infirmier Diplômé d'Etat*
HIV	Human Immunodeficiency Virus
VII	Vaccine Independence Initiative
IMS	Medical-social Nurse - *Infirmier Médico-social*
NID	National Immunisation Days
LQAS	Lot Quality Assurance Sampling
AEFI	Adverse Event Following Immunisation
HP	Head Physician
MEF	Ministry of Economy and Finance
MFP	Ministry of Civil Service - *Ministère de la fonction publique*
MICS	Multiple Indicator Cluster Survey
LLITN	Long-lasting Insecticide-Treated Net
Moughataa	An Administrative Entity (Health District)
MH	Ministry of Health
NKTT	Nouakchott, Capital of Mauritania
CBO	Community-based Organisation
MDG	Millennium Development Objectives
WHO	World Health Organization
NGO	Non-governmental Organisation
ONS	National Office of Statistics - *Office National des Statistiques*
UN	United Nations
CSO	Civil Society Organisation
IMCI	Integrated Management of Childhood Illnesses
PCV-13	Pneumococcal Conjugate Vaccine
PENTA	Pentavalent Vaccine

EPI	Expanded Programme on Immunisation
AFP	Acute Flaccid Paralysis
EFP	Essential Family Practices
NHDP	National Health Development Plan
cMYP	Comprehensive Multi-Year Plan
HO	Health Outpost
PSDRH	Strategic Plan for Human Resources Development - *Plan Stratégique de Développement des Ressources Humaines*
AWP	Annual Work Plan
TFP	Ministry of Labour and Civil Service
APR	Annual Progress Report
RED	Reach Every Child
GCPH	General Census on Population and Housing
HR	Human Resources
HSS	Health System Strengthening
SARA	Service Availability and Readiness Assessment
GS	General Secretariat
NHIS	National Health Information System
UFV	Fixed Immunisation Unit - *Unité Fixe de Vaccination*
MU	Monetary Unit (Ouguiya, National Currency)
UNICEF	United Nations Children's Fund
USB	Basic Health Unit - *Unité de Santé de Base*
MCV	Measles-containing Vaccine
TT	Anti-tetanus Vaccine
Wilaya	Region
ZCI	Target Intervention Zone - *Zone Cible d'Intervention*

PART B: BACKGROUND INFORMATION

6. Description of the national health sector (1-page maximum)

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

The description of Mauritania's health sector will address the main parts of the system:

1- Sector governance and steering:

Since 2012, the health sector has had a 2012-2020 NHDP. Within this framework, the final decision making body is the NSC-HS. This entity's rules of organisation and operation are defined by Order (see Attachment no. 15). Other specific coordinating entities also exist: the

ICC is focused on EPI management and the CCM is responsible for Global Fund grants.

2- Health services:

Mauritania's national health sector has three service levels and three steering levels:
- The operational level, coordinated by management teams from the districts/moughataas, where there are three types of facilities (moughataa hospitals, HCs and HOs). Support at this level includes the installation of basic health units in villages with more than 500 residents or 100 households which are located further than 10 km from a health facility.
- The intermediary level, coordinated and monitored by management teams from the Directorates of Regional Health Action - DRAS (*Directions régionales de l'action sanitaire*).
- The third (tertiary) level is made up of the Ministry of Health's departments and health referral establishments, including private referral clinics.

NHIS data reveals a national curative service use rate of 44% and a national geographic accessibility rate of 80% (2014 Annual Statistical Yearbook).
In 2014, EPI data (2016-2020 cMYP) revealed that polio3, Penta3 and MCV national coverage rates were 81.3%, 81.2% and 75.1%, respectively.
According to the 2016 SARA survey results, immunisation service offerings have improved, increasing from 52% in 2013 to 65% in 2016.
The increased offerings in public hospitals (from 30% in 2013 to 89% in 2016), show that the government's is making efforts in this direction. The average operational capacity score has increased slightly, from 79% in 2013 to 84% in 2016. As in 2013, close to 80% of the health facilities offering immunisation services do not have all operational capacity tracer elements.

In 2016, there was a vaccine stock-out that affected 7 to 15% of health facilities and lasted for the three months preceding the survey. The stock-outs clearly occurred more often in 2013 (between 26% and 33% of health facilities were affected).

3- Human resources for health:

A Strategic Plan for Human Resources Development - PSDRH (*Plan Stratégique de Développement des Ressources Humaines*) was created in 2006 for the 2006-2015 period, but was not implemented and has not been updated since the 2012-2020 NHDP was created.
According to Ministry of Health sources (2014 Annual Statistical Yearbook), doctor/midwife ratios were 0.31/10,000 residents and 0.35/5,000 residents, respectively.
Human resources are very unevenly distributed to the benefit of urban areas and there is also a lack of competency that is related to there not being a continuous training strategy.

4- Material, infrastructure and input resources:

Despite efforts to create health facilities (HOs and HCs), 20% of the population still does not have access to a health care facility within 5 km (2015 Annual Statistical Yearbook).
Infrastructure and equipment maintenance, particularly cold chain equipment, suffers from the lack of a maintenance plan.
According to 2016 SARA survey data, there is still poor availability of essential drugs. In 2016, access to essential drugs is at 26% and this is a two-point decline from 2013 (28%).
Specifically with regards to immunisation, the effective vaccine management (EVM) assessment conducted in 2014 reveals that storage capacity is satisfactory at the national level with a score of 86%, but also shows that it is unsatisfactory at the intermediary and peripheral levels (2015 Gavi/HSS joint appraisal report).

5- Funding:

The four main sources of funding for the health sector in Mauritania are: household participation via direct payments, the government's budget, health insurance, and external

bilateral and multilateral support.
In 2015, the MH's portion of the General State Budget was 4.6% with a completion rate of 97%.

6- Health information:

Mauritania's health information is based on five sub-systems that are currently being integrated into a new tool (DHIS 2) for collecting, validating, processing, analysing and presenting health information.

7- Community and other local actors:

The 2014 external EPI review indicates that the reasons for children not being immunised and for low involvement at the community level include ignorance, misconceptions and the weakness of CSOs and BCOs in rural areas.

7. National Health Development Plan (NHDP) and relationship with cMYP (2-page maximum)

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

*Provide: **Mandatory Attachment no. 8**: NHDP and **no. 11**: **cMYP**; and, if available: **Attachment no. 18**: Joint Assessment of National Health Strategy (JANS); and **Attachment no. 19**: Response to JANS.*

Mauritania has a 2012-2020 National Health Development Plan (NHDP). Axis 2 priority NHDP initiatives include prevention, curative and promotional actions. Those related to infant health and nutrition, immunisation and IMCI activities are particularly important. Implementation of actions to fight infectious diseases (Axis 3 of the NHDP) and health system strengthening (Axis 5 of the NHDP), in combination with the preceding initiatives, will have a significant impact on children's health.
The objectives and actions related to strengthening immunisation coverage and the introducing new vaccines are included in the 2012-2020 National Health Development Plan (NHDP) along with high-impact initiatives for reducing mortality in children under-five—see Axis 3 of the NHDP: combating under-five mortality.
Within the framework of health system strengthening, the NHDP has identified: (i) the development of human resources for health (HRH) as a means to bridge the disparities in how these resources are geographically distributed and to cover staffing needs in the most remote facilities; (ii) re-activating the community approach as a priority strategy in an environment marked by a dispersed population and low use of preventive and promotional services. It is also a priority to provide access to quality drugs, vaccines and supplies to resolve dysfunction in the national pharmaceutical sector. Implementation of the NHDP will require a significant effort to develop an information and communication system. This will involve health information, communication for social and behavioural changes within the population, information management including financial information, and, communication [sic] and advocacy.

The 2016-2020 cMYP has been developed to focus on these issues and with an overall objective of contributing to reduced morbidity and mortality for vaccine-preventable diseases (page 55 of the cMYP).
The country has not yet had the opportunity to organise a JANS. However, the Ministry of

Health is committed to a mid-term NHDP review. In addition, within this framework, a SARA survey and an MICS survey were conducted in February 2016 and in the first quarter of 2015, respectively. The results from these two surveys are available.
Furthermore, a joint performance appraisal of Gavi grants in Mauritania was carried out in 2015 (see attached copy). This appraisal report provides an overview of the immunisation outcomes for the 2011/2014 period. These outcomes are: (i) an increase in penta3 immunisation coverage from 75% in 2011 to 92% in 2014 (EPI external review), (ii) an increase in the number of moughataas with a penta3 immunisation coverage rate of higher than 80% from 9 (17%) of them in 2010 to 37 (70%) of them in 2014, (iii) the introduction of new vaccines: (1) in 2013, the pneumococcal vaccine (PCV-13), (2) in 2013, the tetanus-diphtheria (TD) vaccine as a replacement for the TT vaccine, and (3) in 2014, the rotavirus diarrhoea vaccine.
The recommendations from this Gavi joint appraisal are as follows:

- increase immunisation accessibility by opening fixed immunisation units, obtaining logistical resources, strengthening staff communication capacity.
- application of the Reach Every District (RED) strategy: Reach Every District (RED).
- procurement of ground transportation for mobile activities as well as extending Gavi/HSS intervention to include new moughataas.
- strengthen activity monitoring and evaluation by the Directorates of Regional Health Action (DRAS) (immunisation and HSS).
- strengthen communication promoting immunisation.

Some of these recommendations were included in the new 2016-2020 comprehensive multi-year plan (cMYP).

8. Monitoring and Evaluation Plan for the National Health Development Plan (2-page maximum)

Provide background information on country M&E arrangements.

Monitoring and evaluation of the grant implementation will be integrated into the global M&E framework for health-related activities, as defined in the 2012-2020 NHDP.
As soon as the proposal is endorsed by the Gavi board, it will be widely distributed to those involved in implementation at all levels (moughataas, DRAS, national level, involved civil society, etc.) and others. In addition, an informational meeting about the grant implementation will be organised so that the M&E mechanisms and tools to be used can be presented.

Institutional System
At the national level, the following entities will be involved in activities related to monitoring and evaluating the grant:

- the NHDP steering committee and the ICC (both chaired by the Minister of Health) meet to review and endorse the annual joint appraisal report for the grant (or the annual grant tranche's implementation status). They provide instructions and recommendations to correct deficiencies and improve grant implementation.
- the technical monitoring committee for the Gavi/HSS grant is made up of representatives of those involved (DPCIS, DSBN, EPI, DLM, NHIS, FTPs, ZCI DRAS). It meets two times per year to review implementation activity and the financial absorption rate. It takes measures to correct implementation delays as soon

as possible and to remove various obstacles that impede carrying out activities.

- [it is] the entity in charge of coordinating operational implementation of the grant. It will regularly collect relevant information to be submitted and ensure monthly monitoring of the implementation process. The technical committee prepares for the NSC-HS, ICC and technical committee meetings. It is in charge of monitoring the implementation of recommendations made during above entities' meetings.

At the intermediary level (wilaya), there will be a committee made up of DRAS members and head physicians from the targeted moughataas. Every quarter, it will examine implementation of the regional tranche of the grant.
At the district level (moughataa), the district management team and civil society participants, if any, will carry out bimonthly monitoring of the implementation of moughataa grant activities. These activities must be integrated with the moughataas' annual operational plans.

Mechanisms and tools used
The grant will be divided into annual tranches and at the beginning of each year, the tranche will be accessed, updated using the previous tranche's appraisal and integrated into the annual plans of those involved in the implementation process.
For technical monitoring, routine primary data will be provided (or collected) by the operational units (health posts, health centres, CSOs/BCOs), and transmitted to the district management teams who will proceed to enter, process and analyse them. This information will then be submitted to the national level (EPI, NHIS) electronically via the DRAS. The EPI and NHIS programmes provide information to the entities in charge of coordinating the grant and who must designate a focal point who is responsible for this task.
Regarding this provision, the target district managers will transmit activity DRAS-endorsed implementation reports to the entity responsible for grant management. A dashboard will be created for all levels to rapidly and clearly identify implementation gaps. Having a policy on retro-information and supervision will allow corrective measures to be defined and executed, as needed.
Understanding various impact indicators will require surveys, studies and evaluations. It is in this way that monitoring and evaluation will benefit the following surveys which are regularly carried out in Mauritania: SARA, MICS, EPCV, national health accounts, DHS.
For financial monitoring, in addition to those involved in implementation, departments from the Directorate of Financial Affairs will also be involved.
All this data will be used for annual reports that will be presented to NSC-HS and ICC during annual health sector reviews.
An annual sector review is organised regularly and all the FTPs are invited. This institutional measure is part of the NHDP implementation monitoring mechanism.

Data sources, distribution
The description of the mechanisms above show that the monitoring and evaluation processes will be populated from two main sources:

- Administrative data (having to do with immunisation but also with other HSS elements) collected by the EPI and NHIS.
- The factual data generated from the surveys, studies, evaluations, etc.

Within the framework of the NHDP, the NHIS is the main tool for (1) producing and distributing health information specifically via the Annual Statistical Yearbook as well as weekly epidemiological summaries; (2) developing collection tools and processing, storing and sharing data; (3) diversifying statistical sources of data within the health sector by developing the necessary statistical surveys; (4) coordinating the health information system with a view toward improving performance and consistency. There are five sub-systems:
(i) the routine health services sub-system based on the collection and analysis of routine

statistical data from public and private health facilities; this data is collected from monthly first-level health facility reports (HOs, HCs and hospitals) and quarterly regional reports.
(ii) the epidemiological surveillance sub-system is managed by the Directorate for Disease Prevention and includes an early alert system for a certain number of priority diseases, using information that is provided weekly;
(iii) the information sub-system within a specific programme is "complementary" or "parallel" to essential data collection systems (technical and financial) and is directly controlled by the coordinating arm of the programme in question;
(iv) the information sub-system for resource administration and management is controlled by the various central directorates (HRH, DIMM, DAF) who have developed parallel systems of their own that allow them to monitor management of their resources;
(v) the sub-system for periodic surveys and studies carried out within the framework for implementing various health programmes. There are Expanded Programme on Immunisation reviews, nutritional surveys or other prevalence surveys on various health phenomena as well as opinion surveys from users of health services.
The NHIS has acquired a certain level of independence since becoming a national health programme. It benefited from a 2013-2015 development plan.

Within the framework of setting up the new DHIS 2 (District Health Information System 2) system, along with mapped GPS data about healthcare offerings, the NHIS should be able to improve the availability of quality information.

*Provide **Mandatory Attachment no. 9**: National Monitoring and Evaluation Plan (for the health / strategy sector**),** as well as all national sub-plans, as applicable. If there is no National M&E Plan, explain how the NHDP is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment no. 16**: Data Quality Assessment (DQA) report; and **Attachment no. 17**: Data quality improvement plan.*

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

9. Alignment with existing results-based funding (RBF) programmes (as applicable) (1-page maximum)

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

If yes, provide **Attachment no. 30**: Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.

An RBF feasibility study was conducted in Mauritania in April 2015 and concluded that implementation of RBF in Mauritania is indeed feasible if certain conditions are met.
A National Funding Strategy document based on health sector results that was developed in August 2015 (Attachment 30) defined three main strategic axes. They are (i) improving coverage of health service offerings, specifically for the poorest of the poor, (ii) strengthening the quality of services offered, and (iii) incentives for optimal use of health services. The strategy document's objective is to clarify the government's vision on this topic and to facilitate implementation of a pilot experiment.

A discussion is currently under way between the World Bank and the Mauritanian authorities about a new health initiative that will focus on results-based funding (RBF).

The Gavi/HSS grant will not cover initiatives that are supported by the World Bank or other partners. The grant is focused on implementing the initiatives recommended in the NHDP

and the cMYP to improve child health indicators and specifically immunisation.

This proposal focuses on actions that contribute to strengthening the various levels of the health system so that efficient measures can be taken to improve immunisation coverage. The actions proposed are well aligned with EPI activities that receive Gavi support, such as support for new and underused vaccines and support for immunisation services.

The programme's outcomes are going to positively impact EPI management by strengthening service provider capacity, re-activating EPI monitoring activities, and contributing to improved EVM.

PART C: APPLICATION DETAILS

10. Health system bottlenecks to achieving immunisation outcomes (3-page maximum)

*Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach **Optional Attachment no. 33**: Health System Bottleneck Analysis.*

The definition of bottlenecks was created by analysing the following documents: the 2012-2020 NHDP, the Ministry of Health's 2015 Balance Sheet and 2016 Action Plan, the 2014 Annual Statistical Yearbook, the 2015 Gavi/HSS 2015 Joint Appraisal, the EPI Review Report, the 2014 Effective Vaccine Management (EVM) Assessment, the 2016-2020 EPI Comprehensive Multi-Year Plan, the 2016 EPI Operational Plan, the 2014 Mauritania Poverty Profile, the 2015 Health Sector Review Report and the main results from the 2016 SARA Survey.
The main health system bottlenecks limiting immunisation outcomes are noted by activity type and by health system level:

Sector governance and steering:
Health and immunisation system bottlenecks related to weak institutional capacity are found at each level of the system.
At the national level:
- Poor coordination within the sector: the irregular nature of meetings to coordinate vertical programme initiatives and Cabinet units with central department initiatives makes communication difficult and increases activity fragmentation.

At the regional level:
- The lack of a formal framework through which teams within the same region can share information and coordinate: no systematic monitoring or review of immunisation activities in the regions or moughataas.
- Lack of health mapping leads to a failure to clearly understand the target populations and how they are distributed for each immunisation strategy (2016-2020 cMYP).
- Planning for EPI initiatives is inadequate at the intermediary and operational levels, and specifically as related to micro-planning in the first tier (health centres and health outposts) (2016-20 cMYP).
- Weak community involvement in health system management due to the inertia of health facility management committees. This characterised by a lack of participative planning or effective involvement with local partners and communities (2016-2020 cMYP, 2014 Joint Appraisal)

Human resources for health:
At the national level
- A lack of human resources competent in public health, epidemiology, socio-anthropology,

etc., at all levels of the healthcare system, and, in particular, at the national level, noticeably limits the department's actions.

At the regional level
- Human resources that are quantitatively and qualitatively inadequate (2014 Joint Appraisal), often with a head physician from the Moughataa Health Centres simultaneously acting as a health centre head physician
- Lack of continuous training for decentralised health facility staff requires that a sustainable strategy for service provider capacity be developed (2015 Health Sector Review)

Health service offerings:
- Health coverage is still inadequate at the national level. 40.5% of household members must access a health facility that is more than 60 minutes away, instead of the 30 minutes required by WHO (2014 Mauritania Poverty Profile).
This is more marked in rural areas where 64% of households are more than 60 minutes away from a health facility.
- Geographic coverage for routine immunisation is inadequate because only 53% of health facilities provide routine immunisation services, with immunisation services being discontinued due to disrepair of cold chain equipment or lack of ground transport (2016-2020 cMYP).
- The irregular nature and poor quality of monitoring and supervision of health activities in general, and immunisation activities in particular (2016 EPI OP).
- Poor biomedical waste management, specifically for waste hose produced by immunisation activities. This is a danger for users of health facilities and for the environment and there is no standard method for disposing of waste (2016-2020 cMYP).

Health information:
At the national level:
- The lack of documentation and archiving, particularly technical aspects such as notes, projects, reports and minutes related to supervision activities. In addition, entities that provide coordination or management function poorly.
- The lack of health system research and knowledge management

At the regional level:
- Low levels of competency for regional and local individuals involved with the NHIS (lack of training as well as lack of data collection tools),
- Inadequate immunisation data management at the regional and operational levels (entering data multiple times, analysis and feedback that is not systematic) (2016-2020 cMYP).
- The lack of independent monitoring or routine immunisation activities and the absence of reliable disaggregated data;

Material, infrastructure and input resources:
At the national level:
- The availability of essential drugs has declined in 2016 compared to 2013 (2016 SARA).
- Frequent essential drug supply shortages (2015 Health Sector Review Report).
- Lack of a health equipment maintenance plan, and more specifically, lack of a plan for the maintenance of preventive and curative cold chain equipment (2016-2020 cMYP).

At the regional level:
- Poor vaccine and vaccine material management and inadequate documentation (2016-2020 cMYP); only one EVM criteria out of the 8 evaluated in 2014 attained a score of 80%; these weaknesses mainly affect maintenance, stock management and the information system (2014 EVM).

- At the moughataa level, none of the 8 applicable criteria received the minimum score of 80% (2016-2020 cMYP, 2014 EVM).

(As a reminder, the 9 EVM evaluation criteria are: 1) vaccine receiving procedures, 2) vaccine storage temperatures, 3) storage capacity, 4) buildings, cold chain equipment and transport, 5) building, cold chain equipment and transport maintenance, 6) inventory management, 7) vaccine and supply distribution, 8) vaccine management (correct and efficient use of diluents from the VVM, POV, monitoring management indicators, etc.) and 9) information system and management support.)

Health funding:
At the national level:
- The lack of financial resources: budget allocations for immunisation declined by 40% in 2011 and 7% in 2013 (2016-2020 cMYP);

At the regional level:
- Independent decentralised administrative management does not have measures to ensure transparency and efficient use of resources;

Community and other local participants:
- Inadequate re-activating of basic health units: - Insufficient quantity and quality of CHWs and community liaisons; this is due to the lack of recruitment mechanisms and systems and the lack of training and incentives for both CHWs and community liaisons (2015 Health Sector Review Report)
- Insufficient quantity and quality of awareness-raising and social mobilisation activities for promoting immunisation (2016-2020 cMYP)
- Poor implementation of communication activities that encourage immunisation has negatively influenced EPI performance (2016 EPI OP), due in part to weak CSO/BCO communication capacity in rural areas.

Equity and gender:
- Inequitable financial access to health services: households allocated 4.8% of expenses for health expenditures in 2014; however, rural households use two times more resources for health service than those in urban areas: 6.7% as opposed to 3.5%, and according to the analysis of per capita quintile expenditures, health expenditures represent 4.4% for the poorest households (1st quintile) as opposed to 5.8% of the richest households (5th quintile) (2014 Mauritania Poverty Profile).
- Inequitable geographic access to quality health services and specifically immunisation services, for populations in peripheral rural areas zones, nomadic populations, and populations in remote areas.
With regards to gender, health services, and specifically those related to vaccine-preventable diseases, are free and standard for all patients, no matter what their social or economic status, ethnicity, gender or religion. Both girls and boys have the same likelihood of being immunised.
However, a part of the population lives in a precarious situation and women and children, who are the most vulnerable, are the most at risk. In 2015, more than one in six Mauritanian women (15.3%) did not have prenatal coverage and 30.7% women give birth without medical assistance (2015 MICS)
Parity between girls and boys has been reached for basic education. For access to primary education, the ratio of girls to boys was 1.07 in 2015 (2015 MICS)

Pooled fund *applicants are required to provide a reference to the relevant section and pages in the NHDP which outline how lessons learned from the previous NHDP have been incorporated into the current NHDP plan. If available, attach documentation on lessons learned implementation of the*

pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.

11. Health system bottlenecks to be targeted through Gavi/HSS support (2-page maximum)

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

To make a noticeable impact on improving the country's immunisation coverage, Gavi/HSS2 support will be applied to a specific area: the ZCIs with moughataas that benefited from Gavi/HSS1 reprogramming initiatives. This target zone was determined using criteria identified and unanimously endorsed by the Technical Committee in charge of preparing the proposal (beneficiary of Gavi/HSS1, poorer than the rest of the country, less penta3 coverage, low-performing in terms of immunisation: high penta1-penta3 dropout rate, lower coverage for basic service package (HC within 5-km radius) and more populated).
In this manner, 23 moughataas were selected as priority ZCIs for the programme, for a total population of 1,450,777 residents in 2016. Among this group, 288,935 were children aged 0 to 5, and it is estimated that there will be 65,275 pregnant women and 54,402 live births. In 2015, health coverage within a 5-km radius in the ZCIs was 77%, penta3 coverage was at 74% and the poverty rate was 31%. (An explanatory note about the ZCI selection process can be found in attachment.)

The grant will target the bottlenecks listed below:

1) human resources that are both quantitatively and qualitatively inadequate at the national and regional levels. This is to be addressed by implementing a sustainable strategy to build capacity and to provide continuous training for service providers on public health and curative care. The goal of this is to provide attractive, high-quality health and immunisation activities.

2) the lack of equity in geographic and financial accessibility to quality health services, and specifically immunisation services. This mainly affects populations found in peripheral rural areas, nomadic populations and populations found in remote areas,

3) weaknesses present in effective vaccine management and effective immunisation input management, specifically with regards to maintenance and including the availability of essential drugs at both the national and regional levels,

4) the lack of mechanisms and tools for governance at the national and regional levels interferes with coordinating and planning initiatives within the sector, accessing target populations and distribution, and community involvement in health system management—specifically in immunisation management.

5) Both the regional and operational levels have inadequate information systems for documentation, archiving, health system research, knowledge management, and, specifically, for immunisation data management.

6) An inadequately implemented strategic community approach for complementary healthcare services and lack of a consistent and effective communication efforts that focuses on social and behavioural change.

Pooled fund *applicants are not required to complete this question.*

12. Objectives of the NHDP and application (2-page maximum)

Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/or specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in ***Attachment no. 6*** *- detailed work plan, budget and gap analysis.*

Pooled fund *applicants are not required to prepare separate objectives, rather to list the key objectives from the NHDP, including ones relevant to immunisation.*

Objectives	Description
Objective 1: By September 2022, at the national level, strengthen the availability of competent human resources in the ZCIs and coordinating entities	The development of human resources is one of the Axis 5 priority NHDP initiatives with a view to reaching the plan's objectives. The lack of human resources is a weakness pointed out in the 2016-2020 cMYP. As a support for immunisation, the cMYP identified the need for strengthened EPI staff capacity to improve EPI performance at all levels. The strategic Axis 4 of the cMYP advocates for increased training before human resources are hired and the time during which they are employed as well as the development of new, relevant programmes in which immunisation plays a role in the comprehensive fight against disease. This objective will mainly focus on improving health worker competency in the ZCIs and at the national level, through continuous training for public health programmes, incentive measures and better task distribution. Planning, implementation, monitoring and evaluation and preventive equipment maintenance are particularly important, and the cold chain maintenance, as recommended by the NHDP, is also important. The objective also targets meeting peripheral level training needs at the peripheral level for all EPI components (2016-2020 cMYP), specifically with regard to epidemiological surveillance at the community level and operational rotavirus research. It also targets strengthening operational teams by recruiting health workers from the active work force.
Objective 2: By September 2022, improve community participation and financial and technical transparency within the ZCI health systems	Objective 2 strengthening targets involve governance mechanisms and tools at the national, intermediary and operational levels. Strengthening will be accomplished by relaunching management and health training committees in the first tier as well as through intersectoral coordination at the moughataa and regional levels (CRDSS and CDDSS). The NHDP recommends that there be specific planning, monitoring and control processes for revenue proper to the healthcare system. These should be accomplished through mechanisms involving public health institution governance that involves beneficiary representatives. In this way, citizen control of institutional management will be strengthened by monitoring the populations' financial access to services and particularly access by the most vulnerable part of the population. Implementation and re-activation of coordination entities at the national, regional and peripheral levels will also play a role. This will guarantee integration, complementarity and a synergy of actions within various areas and at various levels. Furthermore, one of the reasons for poor absorption of the funds allocated by immunisation partners is noted in the 2016-2020 cMYP

	as a lack of understanding of the information system as it relates to EPI funding. This is specifically due to the lack of financial information being produced and processed, the inability to make management norms standard and the low use of financial accounting management tools. Objective 2 will focus on strengthening peripheral operational planning capacity, contributing to the implementation and use of financial management tools that are more efficient, effective and transparent, while also strengthening the information system at both the regional and operational levels.
Objective 3: By September 2022, in the ZCIs, strengthen basic health service coverage including immunisation, using the RED approach	This objective focuses on decreasing inequities in geographic and financial accessibility to quality health services, and specifically to immunisation services. These inequities mainly affect populations found in peripheral rural areas, nomadic populations and populations found in remote areas. This will improve the supply of healthcare services and immunisation services being offered in the ZCIs by extending the coverage of health service offerings in accordance with the priorities defined in the 2016-20 cMYP, and, in that way, will contribute to reducing healthcare expenditures by rural populations and the poorest populations. In complementarity with other programme initiatives (such as GFATM), Objective 3 is part of the implementation framework for the major sector reforms recommended by the NHDP. These recommendations are to re-activate community participation by having communities involved in service offerings. In 2020, the plan is to have an 85% availability rate for community staff members (community health workers and community liaisons). This outcome will result in basic healthcare being available to communities and the development of awareness-raising activities and social mobilisation to promote immunisation. This would also reduce the waste that occurs between immunisation rounds and decrease the dropout rate. In addition, activities to be developed will also include outreach and mobile strategies for bringing healthcare to remote populations. This is in alignment with Axis 2 of the NHDP that addresses reducing under-five mortality through high-impact immunisation activities. Implementation of Objective 3 activities will be facilitated within the framework of the reprogrammed HSS1 activities. Activities to be implemented are related to ground transportation (to assist with transporting teams), cold chain equipment (to improve vaccine and input storage capacity in the ZCIs), and incinerators (to support immunisation waste management). The cMYP shows that one of the main problems in implementing the RED approach is that there is a discontinuity of immunisation services due to, among other reasons, a cold chain in disrepair. Ongoing immunisation services provided by the fixed immunisation units are not guaranteed due to problems related to the EVM. An assessment conducted in 2014 as part of the EVM showed that no criteria received a minimum score of 80% at the regional or moughataa level or in the HCs or Hos (except for vaccine storage temperature). This is important because an indicator is only considered valid when it attains a score equal to or greater than 80%. Objective 3 will focus on guaranteeing quality vaccines, avoiding stock-outs and providing continuous service by monitoring the cold chain and vaccine management. To accomplish this, regular monitoring of cold chain equipment, ground transportation and

	buildings is planned for the moughataa level. This activity will be integrated into the inventory process and CCE maintenance activities within the ZCIs. The implementation framework for the national cold chain equipment maintenance plan will include the organisation of an annual visit by the regional team to supervise maintenance activities, train local teams and resolve problems on site. This activity will occur in conjunction with a country-wide inventory that will be conducted by the EPI in 2016. After this has been completed, a proposal will be submitted to Gavi for funding a cold chain rehabilitation plan.
Objective 4: By September 2022, increase the use of health services by stimulating demand.	This objective focuses on communication activities related to changes in behaviour that, at the first tier, are a crucial component of its activities. According to the 2016-2020 cMYP, these activities are key to the Expanded Programme on Immunisation being able to attain objectives related to targeted immunisation coverage and efficient epidemiological surveillance. Communication activities have improved due to partner support during immunisation campaigns and due to contributions from the community liaisons and the CSOs/BCOs. The Expanded Programme on Immunisation has a strategic communication plan that was drafted in 2013. This plan is built around the following strategic axes: (i) advocacy at all levels (national, regional, departmental (moughataa) and community), (ii) social mobilisation at all levels (national, regional, departmental and community), (iii) communication that addresses changes in behaviour and social change, (iv) strengthening the capacity of health staff in charge of immunisation as well as community liaisons, and (v) coordination/ monitoring / supervision/ evaluation of all activities at all levels (national, regional, departmental and community). Due to a lack of funding, this national plan is not operational at the moughataa level and even less so in the health outposts. In compliance with the cMYP, in the ZCIs, Objective 4 will contribute to the implementation of a communication plan developed in conjunction with community entities. It will improve communication and guarantee service offerings. Training of health staff on efficient communication techniques for convincing those who hesitate to have their children immunised and to participate in reporting serious AEFI cases (Adverse Events Following Immunisation) will make it possible to maintain a certain degree of confidence and dispel fears. Furthermore, this objective will support improving service quality in the ZCIs by identifying beneficiary satisfaction factors and improving the health worker skills so they can provide quality care. The strategy of providing free services for children under 5 and for pregnant women will also be pursued in the 9 original moughataas in the Gavi/HSS1 ZCIs. This strategy will then be evaluated and a recommendation will be made to the government to scale up this approach or not.
Objective 5: By September 2022, strengthen monitoring and evaluation and epidemiological surveillance capacity in the ZCIs and at the national level	Epidemiological surveillance was established by a different department (DLM) than the one to which the EPI belongs (DSBN); this demonstrates a bottleneck impeding coordination between two complementary entities. A conceptual framework defined in the NHDP currently serves as a template for the monitoring process. It involves holding regular reviews at the national level which are to be preceded by regional reviews. Management of the surveillance database is a cMYP priority. This objective focuses on providing wilaya and moughataa institutions

	with the human, logistical and financial resources needed to carry out this type of management. For development of the 2016-2020 cMYP strategies, the plan intends to strengthen surveillance through several initiatives that will optimise EPI performance with regard to immunisation data management, changes observed in disease epidemiology and data management related to vaccine safety as well as and supervision and community epidemiological surveillance. Objective 5 focuses on improving sector monitoring and evaluation and country-wide epidemiological surveillance as well as the implementation of the DHIS 2 as an integrated health information platform. Objective 5 also includes monitoring and evaluation activities related to this proposal's implementation.

13. Description of activities (3-page maximum)

*Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in **Attachment no. 6** - Detailed budget, gap analysis and work plan.*

***Pooled fund** applicants are not required to complete this table, but should provide relevant sub-sections of the NHDP focusing on immunisation, including the annual work plan, activities and budget; **Attachment no. 34**: Pooled fund Annual Work Plan and Budget (AWPB) and related Terms of Reference.*

Objective / Activity	Explanation of link to improving immunisation outcomes
Objective 1: By September 2022, at the national level, strengthen the availability of competent human resources in the ZCIs and coordinating entities.	
1.1 Update national continuous health staff training plan	There is a continuous training plan for that specifically focuses on paramedical staff. It dates from 2003. This plan will be updated and take into account training that new health workers have received about the operational aspects of public health programmes such as the EPI. These trainings consist of bringing all categories of health staff up to standard as needed for various positions. An emphasis will be placed on priority continuous health staff training for peripheral facilities, in alignment with the measures outlined in the national health tasks delegating strategy. This update will be carried out by a consultant who is an expert in training and who will do so under the supervision of a designated committee. The update will be endorsed in workshop.
1.2 In the ZCIs, ensure continuous training of health workers on childhood diseases and initiatives in the main health programmes.	In the ZCIs, an updated continuous national training plan will be implemented. When possible, this activity will take place in health schools which can provide a location with adequate resources and the required pedagogical approaches. Strengthening health staff capacity will improve diagnoses and management of childhood diseases and especially those targeted by immunisation, as well as AEFI

	cases. Continuous training will be integrated into the main health programme initiatives, and, in particular, into the EPI. Training for workers completing their studies at health schools and for newly assigned workers will be a priority. The training will also help fill vacant immunisation worker positions that currently have a 37% vacancy rate (236 out of 630 positions are vacant) according to the 2016-2020 cMYP.
1.3 Develop and disseminate position descriptions per the national strategy for delegating tasks.	The various positions within the health system must be defined and edited and the descriptions must include a list of related tasks. This activity will assist health workers in better understanding their roles and responsibilities, teams in better distributing tasks while taking into account the profiles of workers who are available, and improve the country's task delegation strategy. It will help improve productivity and immunisation outcomes.
1.4 Strengthen human resource capacity in the main programmes and services so that they are qualified in epidemiology and public health.	This activity consists of mobilising competent technical assistance to strengthen the strategic level (DPCIS, EPI Coordination) and training management staff at the operational level. At both the national level and in the ZCIs, the activity will contribute to improved understanding of health problems. The DPCIS development plan (see attachments) highlights the strategic role of this direction in terms of planning, monitoring and sector data production, and shows that one of the weaknesses that needs to be addressed is the lack of qualified staff in the field of public health. Furthermore, all Moughataa Health Centres in the ZCIs are directed by managers who have received little or no training in public health. This activity will also have a positive impact on managing immunisation at both the national and operational levels.
1.5 Pay salaries to additional staff recruited from among retired Moughataa Health Centre workers in the Gavi/HSS1 ZCIs	This activity will stem the terrible HR deficit that negatively influences health activity implementation and the immunisation programme, and, specifically, the ability to reach NHDP and cMYP objectives. Despite the will to accomplish this, the brief Gavi/HSS1 experience seems to indicate that the candidates being recruited think that the amount being offered them is insufficient. This is why only 4 workers have been hired in 3 Moughataa Health Centres out of the 18 open worker positions that were initially approved. This HSS2 grant will continue to use the

	services of the 3 retirees who have already been recruited Before the project is over, the positions held by these retirees will be filled by the Ministry by assigning new workers who have recently graduated from public health schools.
1.6 Pay incentives for tasks delegated to healthcare staff in the 9 Moughataa Health Centres in the Gavi/HSS1 ZCIs	This activity consists of providing every healthcare staff member who carries out delegated tasks with an incentive equal to 50% of the IMS' PZT. In the 9 Moughataa Health Centres that are part of the initial ZCIs, completion of this activity will consolidate the implementation of the task delegation strategy in healthcare that was adopted by the Ministry of Health in 2013. This strategy is one approach for mobilising and motivating staff in the health system's peripheral areas and should be studied further before it is scaled up.
Objective 2: By September 2022, improve community participation and financial and technical transparency within the ZCI health systems	
2.1 Re-activate health facility management committees	This activity is meant to ensure the sustainability of health services, and immunisation in particular, by involving local communities in their management. Local communities are responsible for how resources are used for health training and for monitoring activity implementation.
2.2 Strengthen how regional and departmental socio-health development councils function	The role of these councils is important in mobilising resources and the performing surveillance of health services coverage in the departments and regions. The councils are to support immunisation activities at the administrative level and the community level.
2.3 Ensure participation in the creation of the budgeted annual work plans at the moughataa and DRAS levels in the ZCIs	The annual health activity planning process, specifically for immunisation activities, will be supported from the operational to the intermediary level. It will encourage community participation and local civil society organisations at every moment of the process.
2.4 Develop and distribute a procedures manual and tools for implementation of the budget at the decentralised levels	The procedures manual and budget execution tools will lead to better use and monitoring of financial resources. This applies especially to government resources for operational activities and will also increase the impact of immunisation activity resources.
Objective 3: By September 2022, in the ZCIs, strengthen basic health service coverage including immunisation, using the RED approach.	
3.1 Install basic health units in the ZCIs to provide coverage for areas that are far from health outposts.	The basic health units will help reach a greater portion of the population and increase immunisation coverage. This activity is guided by the community health

	strategy plan implementation document (Attachment: Implementation and Community Health Strategy Plan). From the beginning, this plan involves communities in the implementation of basic health units, through the information and awareness they provide, and through community health worker and community liaisons' desired level of participation. In addition, local trainer-supervisors will organise a series of trainings for community health workers and community liaisons. These trainings will be prepared in advance of the previous two tasks. This activity will lead to developing awareness-raising activities and social mobilisation to promote immunisation. It would also reduce the waste that occurs between the rounds of immunisation and also decrease the dropout rate.
3.2 Implement outreach and mobile strategies for an integrated package of health services	Within the Gavi/HSS1 reprogramming framework, every moughataa in the ZCIs will have the logistic means to carry out mobile and outreach strategies. In this way, they will increase the use of immunisation services and improve immunisation coverage by reaching specific populations (nomadic populations, villages who are located far from health facilities and/or remote areas, etc.). It is important to manage the movement of ZCI management teams by completing these outreach and mobile activities and specifically those related to immunisation. This will improve access to healthcare services by the most vulnerable populations.
3.3 Ensure that integrated supervision takes place regularly in the ZCIs	Regularly carrying out supervision activities using logistical means available in the moughataas in the ZCIs will improve both service quality and availability. This activity will consist of organising an orientation session for Moughataa Health Centre management teams on planning integrated supervision activities and financial contributions to missions. The use of immunisation services will increase due to regular monitoring of health activities and, specifically, of immunisation activities.
3.4 Improve biomedical waste management in the ZCIs	This activity will consist of developing a guide/manual for the biomedical waste management. The manual targeted to health staff and particularly to immunisation staff. Training on this manual will be organised and targeted to health staff located in the ZCIs. The training will improve injection safety and the destruction of immunisation waste, in fixed

	and mobile units.
3.5 Provide a complete inventory of cold chain equipment and ground transportation used for EPI activities in the ZCIs.	Procuring ground transportation and immunisation [supplies] from the HSS1 reprogramming provides an opportunity to extend the coverage of immunisation services. Activity 1.6 will help achieve the tasks described in the EVM improvement plan. This activity will focus on keeping the complete inventory of EPI cold chain equipment and EPI ground transportation up to date. This activity will enable implementation of the programme to distribute vaccine and vaccine supplies. It will be adapted on a yearly basis along with the maintenance strategy. This activity will guarantee the continuity of immunisation services.
3.6 Implement a regional maintenance plan for cold chain equipment, ground transportation and buildings.	Procuring ground transportation and immunisation [supplies] and drafting a maintenance plan within the framework of the HSS1 reprogramming. This is an opportunity to extend the coverage of immunisation services. Activity 1.7 will help achieve the tasks described in the EVM improvement plan. It will focus on maintenance of cold chain equipment, ground transportation and buildings that provide EPI services. This activity will be organised so that a moughataa maintenance team will visit Moughataa Health Centre facilities once per quarter and a regional team will visit them twice per year. This activity will help monitor the work of those who use this equipment (preventive interviews) and make sure that they receive continuous training, ensuring that scheduled equipment maintenance takes place.
Objective 4: By September 2022, increase the use of health services by stimulating demand.	
4.1 Update the partnership framework with the CSOs/BCOs and create tools and procedures to develop local partnerships	This activity consists of developing a partnership framework between the health services and the CSOs/BCOs. This will take into account the specifics of the most peripheral areas, in terms of health services offered, participation of community participants, existence of cooperatives and other CSOs/BCOs. The partnership framework will facilitate the use of immunisation services for the most disadvantaged populations.
4.2 Support promotional activities within the framework of the local partnerships between the Moughataa Health Centres and the CSOs/BCOs	This activity consists, in part, of strengthening local CSO/BCO capacity in the ZCIs so that there are contractual and quality services related to communicating about development and active research on children who are not immunised. The other part of this activity consists of

	organisational support for awareness-raising sessions for local populations and, in particular, those in remote areas. This activity will increase the use of immunisation services by strengthening civil society and community involvement in promoting health services, and specifically, immunisation services.
4.3 Develop a strategy to strengthen health worker capacity in interpersonal communication and relaunch health education activities in the ZCIs	This activity focuses on training health workers who are the first line of contact with patients (triage consultations, pre- and post-natal visits, malnutrition screening, etc.) and those responsible for health-related educational activities in health facilities as well as on health education and interpersonal communication techniques. This activity also addresses providing health education services with appropriate equipment. It will increase the use of immunisation services and improve immunisation coverage.
4.4 Have mechanisms to manage the health care funds to be spent for mothers and children aged from 0 to 5	Toward the goal of using an innovative approach to increase how often mothers (of children aged 0 to 5) use immunisation services and how often pregnant women use them, this activity consists of using an incentive measure that was first used in the Gavi/HSS1 programme. The approach is to ensure free care for pregnant women and for the mothers of children aged 0 to 5 in the 9 Moughataa Health Centres from Gavi/HSS1 in the ZCIs for the first two years. The amount to be compensated to the health facilities will be depend on how frequently services are used, as certified by the management committees. The amounts compensated are based on the equivalent of 1 contact/year for the entire population targeted by the Moughataa Health Centres. This is the calculation that was used for Gavi/HSS1. This approach will be then be evaluated and it may be recommended that the government use it more widely.
Objective 5: By September 2022, strengthen monitoring and evaluation and epidemiological surveillance capacity in the ZCIs and at the national level	
5.1 Strengthen the capacity of surveillance focal points and laboratory technicians	The results of the external review will orient the drafting of the epidemiological surveillance Standard Operating Procedures in the same direction as the ones used in the 2016-2020 cMYP. Training/retraining sessions and supportive supervision will be organised for surveillance focal points and laboratory technicians.

5.2 Conduct three LQAS household surveys in health areas within the ZCIs to monitor administrative data	Firstly, this activity focuses on verifying the progress made in increasing immunisation coverage and on having access to quality data. This will introduce the management teams in the ZCIs to a fast and easy method for monitoring data and health information that is within their jurisdictions.
5.3 Implement community-based epidemiological surveillance	This activity will be carried out through awareness-raising campaigns within communities. Community health workers and community liaisons will be involved as well as community leaders and CBOs such as women's cooperatives and others who are interested in EPI surveillance within the framework of Integrated Disease Surveillance and Response (IDSR). This activity will help monitor diseases targeted for immunisation and AEFI cases within communities, and, in particular, diseases that are found in remote areas and the most disadvantaged areas.
5.4 Conduct two user satisfaction surveys in the ZCIs and come up with specific actions in response to the results.	This activity focuses on analysing the improvements in the quality of health services offered to ZCI populations, and, specifically immunisation services. This activity consists of gathering user points of view to monitor progress related to the quality of immunisation services. It will help increase the use of immunisation services and improve immunisation coverage.
5.5 Support organising quarterly monitoring meetings and meetings addressing activity updates on health and immunisation action plans. The meetings are to be between the DRASs, district head physicians and immunisation focal points.	Support regularly holding meetings to monitor the implementation of regional health action plans and, specifically, immunisation activities. These meetings are held at the DRAS level and bring together Moughataa Health Centre head physicians and immunisation focal points. This activity will make it possible to monitor progress made toward improving immunisation coverage and toward having access to quality data within the ZCIs.
5.6 Support the implementation of grant monitoring.	This involves supporting active monitoring of programme implementation by organising quarterly meetings of the technical grant monitoring committee
5.7 Support organising an annual meeting of the ICC and the NSC-HS.	This activity will make it possible to monitor progress made toward improving immunisation coverage.
5.8 Support establishing DHIS 2.	This involves implementing the DHIS 2 system in the ZCIs through a series of training for regional NHIS/EPI focal points and providing them with supplies and providing the health facilities with appropriately adapted tools for data collection and analysis.
5.9 Organise an annual joint appraisal of the Gavi	This activity will focus on verifying the

programme.	progress made in increasing immunisation coverage and having access to quality data. It will be integrated into the assessment of the innovative approach for increasing the use of health and immunisation services and specifically those used by mothers (with children aged 0 to 5) and pregnant women. The joint appraisal report will be reviewed and endorsed during the NSC-HS meeting.
5.10 Organise a final assessment for the Gavi/HSS2 grant	This activity focuses on understanding how much progress has been made in immunisation coverage and on lessons learned about gains and failures from past experiences.

14. Results chain *(4-page maximum)*

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

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

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

Results chain		
Objective 1: **→By September 2022, at the national level, strengthen the availability of competent human resources in the ZCIs and coordinating entities.**		
Key Activities: 1.1 Update national continuous health staff training plan 1.2 In the ZCIs, ensure continuous training of health workers on childhood diseases and initiatives in the main health programmes. 1.3 Develop and disseminate position descriptions per the national strategy for delegating tasks. 1.4 Strengthen human resource capacity in the main programmes and services so that they are qualified in epidemiology and public health. 1.5 Pay salaries to additional staff recruited from among retired Moughataa Health Centre workers in the Gavi/HSS1 ZCIs	**Intermediate Results:** ▪ Health worker immunisation capacity is strengthened	**Immunisation Outcomes:** ▪ Immunisation coverage improves in the ZCIs ▪ Geographic and socio-economic inequity is reduced ▪ A decrease in the number of children who are not immunised
Related Key Activities Indicators: ▪ The Continuous Training Plan is updated and available to health staff ▪ Number of health workers trained in principal basic health initiatives in the ZCIs ▪ Number of technical assistants recruited to support the national level	**Related Intermediate Results Indicators:** ▪ Percentage of vaccination worker posts in the ZCIs higher than 90%	**Related Immunisation Outcome Indicators:** ▪ Penta3 immunisation coverage in the ZCIs ≥ 95% ▪ MCV immunisation coverage in the ZCIs ≥ 90% ▪ Penta1-Penta3 dropout rate < 10% ▪ Difference in penta3 immunisation coverage between the lowest and highest wealth quintile in the ZCIs

Objective 2: **➔By September 2022, improve community participation and financial and technical transparency within the ZCI health systems**		
Key Activities: 2.1 Re-activate health facility management committees 2.2 Strengthen how regional and departmental socio-health development councils function 2.3 Ensure participation in the creation of the budgeted annual work plans at the moughataa and DRAS levels in the ZCIs 2.4 Develop and distribute a procedures manual and tools for implementation of the budget at the decentralised levels	**Intermediate Results:** ▪ All Moughataa Health Centres in the ZCIs document their expenses in compliance with the current operating manual ▪ All Moughataa Health Centres' AWPs are developed and endorsed by the ZCIs.	**Immunisation Outcomes:** ▪ Immunisation coverage improves in the ZCIs ▪ Geographic and socio-economic inequity is reduced ▪ A decrease in the number of children who are not immunised
Related Key Activities Indicators: ▪ Number of Management Committees installed in the ZCIs ▪ Number of meetings documented by the CDDSS and CRDSS	**Related Intermediate Results Indicators:** ▪ Percentage of operational management committees (at least 2 documented meetings per year) in the ZCIs ▪ Percentage of moughataas that have a AWP that has been endorsed before the end of the 1st half of the year	**Related Immunisation Outcome Indicators:** ▪ Penta3 immunisation coverage in the ZCIs ≥ 95% ▪ MCV immunisation coverage in the ZCIs ≥ 90% ▪ Penta1-Penta3 dropout rate < 10% ▪ Difference in penta3 immunisation coverage between the lowest and highest wealth quintile in the ZCIs
Objective 3: **➔By September 2022, in the ZCIs, strengthen basic health service coverage including immunisation, using the RED approach**		
Key Activities:	**Intermediate Results:** ▪ 95% of the population in the ZCIs	**Immunisation Outcomes:**

3.1 Install basic health units in the selected ZCIs to provide coverage to non-eligible health outposts. 3.2 Implement outreach and mobile strategies for an integrated package of health services 3.3 Ensure that integrated supervision takes place regularly in the ZCIs 3.4 Improve biomedical waste management in the ZCIs 3.5 Provide a complete inventory of cold chain equipment and ground transportation used for EPI activities in the ZCIs 3.6 Implement a regional maintenance plan for cold chain equipment, ground transportation and buildings	have access to immunisation ▪ Immunisation safety practices are followed ▪ Maintenance is carried out for cold chain equipment	▪ Immunisation coverage improves in the ZCIs ▪ Geographic and socio-economic inequity is reduced ▪ A decrease in the number of children who are not immunised
Related Key Activities Indicators: ▪ Number of functioning basic health units within the ZCIs ▪ Number of health facilities benefiting from supervision during the quarter ▪ A complete inventory of cold chain and ground transportation equipment is conducted	**Related Intermediate Results Indicators:** ▪ Number of surviving infants who have received the third recommended dose of the penta3 vaccine in the ZCIs ▪ Number of moughataas in the ZCIs who have conducted at least 4 mobile visits per year ▪ An Effective Vaccine Management score that is equal or higher than 80% in the ZCIs	**Related Immunisation Outcome Indicators:** ▪ Penta3 immunisation coverage in the ZCIs ≥ 95% ▪ MCV immunisation coverage in the ZCIs ≥ 90% ▪ Penta1-Penta3 dropout rate < 10% ▪ Difference in penta3 immunisation coverage between the lowest and highest wealth quintile in the ZCIs
Objective 4: **➔By September 2022, increase the use of health services by stimulating demand.**		
Key Activities: 4.1 Update the partnership framework with the CSOs/BCOs and develop tools and procedures to develop local partnerships 4.2 Support promotional activities within the framework of the local partnerships between the Moughataa Health Centres and the CSOs/BCOs 4.3 Develop a strategy to strengthen health worker capacity in interpersonal communication and relaunch health education	**Intermediate Results:** ▪ Equitable access to information is ensured for all categories of the population in the ZCIs ▪ The demand for immunisation services has increased in the ZCIs	**Immunisation Outcomes:** ▪ Immunisation coverage improves in the ZCIs ▪ Geographic and socio-economic inequity is reduced ▪ A reduction in the number of children lost to follow-up

activities in the ZCIs		
Related Key Activities Indicators: ▪ Number of CSOs/BCOs involved in a partnership with the Moughataa Health Centres in the ZCIs having carried out promotional immunisation activities ▪ Number of health workers trained in interpersonal communication techniques	→	**Related Intermediate Results Indicators:** ▪ Percentage of those responsible for children who know the age at which the 1st childhood vaccine is administered in the ZCIs ▪ Number of surviving infants who have received the third recommended dose of the penta3 vaccine

Objective 5: **→By September 2022, strengthen monitoring and evaluation and epidemiological surveillance capacity in the ZCIs and at the national level.**			
Key Activities: 5.1 Strengthen the capacity of surveillance focal points and laboratory technicians 5.2 Conduct LQAS household surveys in health areas within the ZCIs to monitor administrative data 5.3 Implement community-based epidemiological surveillance 5.4 Conduct periodic user satisfaction surveys in the ZCIs and come up with specific actions in response to the results. 5.5 Support organising quarterly monitoring meetings and meetings addressing activity updates on health and immunisation action plans. The meetings are to be between the DRASs, district head physicians and immunisation focal points.		**Intermediate Results:** ▪ Existence of fact-based health system data that includes immunisation-related data, in the ZCIs ▪ Grant implementation is closely monitored and bottlenecks are removed as needed ▪ The epidemiological alert mechanism is operational in the ZCIs	→ **Immunisation Outcomes:** ▪ Immunisation coverage improves in the ZCIs ▪ Geographic and socio-economic inequity is reduced ▪ A decrease in the number of children who are not immunised ▪ A reduction in the number of children lost to follow-up

Related Immunisation Outcome Indicators: ▪ Penta3 immunisation coverage in the ZCIs ≥ 95% ▪ MCV immunisation coverage in the ZCIs ≥ 90% ▪ Penta1-Penta3 dropout rate < 10% ▪ Difference in penta3 immunisation coverage between the lowest and highest wealth quintile in the ZCIs		

5.6 Support the implementation of grant monitoring. 5.7 Support organising annual meetings for the ICC and the NSC-HS. 5.8 Support establishing DHIS 2. 5.9 Organise an annual joint appraisal of the Gavi programme. 5.10 Organise a final assessment for the Gavi/HSS2 grant		
Related Key Activities Indicators: ▪ Number of health trainings in the ZCIs where at least one individual is trained on improving data quality ▪ Number of surveys/evaluations that are carried out	→	**Related Intermediate Results Indicators:** ▪ Rate of NHIS report timeliness SNIS in the ZCI moughataas ▪ Number of technical monitoring committee meetings with a list of participants and minutes, per year ▪ Number of implementation reports drafted, using a baseline of 2 reports per year.

Related Immunisation Outcome Indicators:

- Penta3 immunisation coverage in the ZCIs ≥ 95%
- MCV immunisation coverage in the ZCIs ≥ 90%
- Penta1-Penta3 dropout rate < 10%
- Difference in penta3 immunisation coverage between the lowest and highest wealth quintile in the ZCIs

IMPACT

Implementation of this programme should help reduce the mortality of children under five.

ASSUMPTIONS

Quality human resources are available in sufficient quantity.

There is availability of financial resources from increased allocations in the government's budget that are targeted at healthcare and the mobilisation of development partner funds to close the gaps.

Logistical resources (vehicles and logistics specific to the EPI) are available.
Inputs are available.
There is effective participation of the CSOs and the BCOs in programme implementation.
There is good governance and transparency in resource management.
There is constant technical support from partners within the sector and from the EPI.
The NHDP is implemented and a monitoring and evaluation plan is available for the 2017-2020 period.

15. Monitoring and Evaluation (M&E) (2-page maximum)

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

Monitoring and evaluation the implementation of this grant will be integrated into the M&E guide (currently being drafted) for activities within the health sector as defined in Chapter VII of the 2012-2020 NHDP.

The purpose of monitoring is to make collection, analysis and processing systematic and to distribute information, identify inadequacies and obstacles, and to alert the entities concerned.

An annual NHDP review will be organised with the full participation of the FTPs and all those involved in the sector. The review will be preceded by regional reviews that will be approved by regional monitoring and evaluation NHDP reports.

Monitoring and evaluation objectives and indicators

Impactful, effective results and the development of products within the NHDP can be used as a basis for defining relevant indicators for each level (once the monitoring and evaluation guide has been developed) In general, monitoring and evaluation of the progress made on the NHDP initiatives and outcomes, is dependent on a well-performing information system that can provide access to the required information in a timely manner. To accomplish this, a re-activated NHIS, integrated supervision and health research will allow for timely access to information from the appropriate level that is required to steer the NHDP.
Understanding various impact indicators will require surveys, studies and evaluations. It is in this way that the monitoring and evaluation will benefit the following surveys which are regularly carried out in Mauritania: SARA, MICS, EPCV, national health accounts, DHS.

Data sources, distribution

Within the framework of the NHDP, the NHIS is the main tool for the (1) production and distribution of health information, specifically via the Annual Statistical Yearbook and the weekly epidemiological summaries; (2) development of collection tools and the processing, storage and sharing of data; (3) diversification of statistical data sources in the health sector by developing the necessary statistical surveys; (4) coordination of the health information system with a view toward improving performance and consistency. There are five sub-systems:
(i) the routine health services sub-system based on the collection and analysis of routine statistical data from public and private health facilities; this data is collected from monthly first-level health facility reports (HOs, HCs and hospitals) and quarterly regional reports.
(ii) the epidemiological surveillance sub-system is managed by the Directorate for Disease Prevention and includes an early alert system for a certain number of priority diseases, using information that is provided weekly;
(iii) the information sub-system within a specific programme is “complementary” or “parallel” to essential data collection systems (technical and financial) and is directly controlled by the coordinating arm of the programme in question;
(iv) the information sub-system for resource administration and management is controlled by the various central directorates (HRH, DIMM, DAF) who have developed parallel systems of their own that allow them to monitor management of their resources;
(v) the sub-system for periodic surveys and studies carried out within the framework for implementing various health programmes. There are Expanded Programme on Immunisation reviews, nutritional surveys or other prevalence surveys on various health

phenomena as well as opinion surveys from users of health services.
The NHIS has acquired a certain level of independence since becoming a national health programme. It benefited from the 2013-2015 development plan.
Within the framework of setting up the new DHIS 2 (District Health Information System 2) system, along with mapped GPS data about healthcare offerings, the NHIS should be able to improve the availability of quality information.

Dissemination and use of strategic information

Re-activating the National Health Information System (NHIS) will allow for:
- Moughataas and independent health facilities (including private health facilities) to regularly collect and analyse data about user health, services provided, and various aspects of management (HR staff, drugs, finances, etc.); a summary of relevant information is sent quarterly to the regional directorates to which the moughataas and health facilities report;
- At the intermediary level, summary and analysis of data to be followed by (i) decision making as result of the data gathered, (ii) the data being sent up to the National Health Information System;
- The summary and analysis of this regional data and its inclusion in the database to be used for publication of the Annual Statistical Yearbook.

The Annual Statistical Yearbook is also used for the following:
- the results of the supervision carried out at various levels and compiled by the relevant entities into a national supervision report;
- the results of surveys conducted within the framework of health programme monitoring and evaluation;
- demographic data that has been updated in close collaboration with the National Office of Statistics;
- management data (HR, drugs, finances) for the directorates, institutions or other Ministries concerned.

These various products – yearbooks and other reports or summaries – will be disseminated at each level. This will allow those involved (the government, civil society, the private sector and the FTPs) to be regularly informed of the situation. This will allow them to actively participate in steering the NHDP.

16. PBF data verification option

Choose which data verification option to be used for calculating the performance payments.

Data verification option	Select ONE
Use of country administrative data	■
Use of WHO/ UNICEF estimates	☐
Use of surveys	☐

PART D: WORK PLAN, BUDGET AND GAP ANALYSIS

17. Detailed work plan, budget narrative and gap analysis (3-page maximum)

*Complete **Mandatory Attachment no. 6**: Detailed work plan, budget and gap analysis, which can be accessed at the online country portal.*

Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.

*Once the budget template and financial gap analysis has been completed, provide a **budget and gap analysis narrative** here.*

The proposed budget translates the programme's financial execution needed to reach objectives. This is based on the unit costs used by several technical and financial partners in Mauritania, if no baseline costs exist.
The budget amount is US$ 3,469,053 and covers a period of 5 years, from October 2017 to September 2022.

When there are recruiting contacts that are billed every six months, costs related to human resources are part of the country's human resources development policy and are not recurring programme costs.

The budget has a work plan that describes planned activity implementation for the duration of the grant period, shown yearly. An activity implementation calendar for the first twenty-four months of the grant is included in the current budget.

A gap analysis for each of the proposal's objectives has been created and is included in the proposal. The analysis shows total resource immunisation need, as defined in the 2016-2020 cMYP. It also provides a projection for 2021 and 2022 that uses an annual average rate of change for the last year (Current Value – Last Year Value)/Previous Year Value x 100), for each activity category, in relation to the various resources for HSS funding available during the programme's duration, from the government and from the FTPs.

Resource needs to be directly and indirectly funded for immunisation are estimated at US$ 118,806,856 and available resources are estimated at US$ 75,386,890 for a gap of US$ 43,419,966

It should be noted that the government's contribution to the grant's implementation is the allocation of funds for the salaries of staff mobilised in the ZCIs, regional management teams, and all staff involved at the national level. The government is also covering all civil engineering infrastructure and other equipment that will be used.
The FTPs' contribution is estimated using information obtained from the partners and/or the DPCIS based on projects that they are currently funding and financial projections.

Those funding the health system strengthening process are the following:
- the government through the state budget allocations for health (4% of the government's overall budget for 2016). The government will cover main strategic inputs for the health system including the cost of human resources, drugs, medical equipment, etc.,
- WHO through its country-wide cooperation strategy for the 2017-21 period; it often focuses on providing support for formulating sector policies,
- UNICEF, through its cooperation agreement for the 2017-21 period, mainly focused on child survival, country-wide,
- UNFPA through its country-wide headquarters agreement for the 2017-21 period,
- AFD through its project to combat maternal, neonatal and child mortality for the 2017-19 period in the wilaya of Assaba,
- the Spanish Development Agency through its institutional support of the basic health system for the 2017-19 period in three of the country's wilayas (Guidimagha, Brakna and Trarza),

- the European Union through its project to support the health system for the 2017-19 period, country-wide
- the World Bank through its results-based funding for the 2017-20 period in a pilot area that includes two wilayas that are being selected,
- the Global Fund through its programme for the prevention of AIDS, tuberculosis and malaria for the 2017-18 period, country-wide.

The proposal includes technical assistance (see activity 1.4) to strengthen the main programmes and services by providing human resources qualified in epidemiology and public health. The technical assistance provided by three consultants will improve the competencies of the facility executing the grant (DPCIS and EPI). This assistance will also train managers at the national, regional and peripheral levels in epidemiology and public health so that such competency is sustainable at all levels of the healthcare system.

This request for technical assistance is perfectly aligned with the implementation of the plan to strengthen the DPCIS in that the DPCIS plays an important role in technical assistance.

***Pooled fund** applicants are not required to complete the work plan, budget and gap analysis template. Instead, specific information on the sector wide annual work plan and budget should be provided.*

8. Sustainability (2-page maximum)

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

he activities that are programmed with Gavi/HSS support are initiatives that are included in the NHDP. This acilitates the sustainability of the results obtained through the programme's implementation.

escribe how the government is going to ensure financial sustainability of the results achieved by the Gavi grant fter its completion.

he sector's strategic plan, the 2012-2020 NHDP, has an objective to increase the funding allocated to health om a current contribution of 4% to a contribution in 2020 that is 14% of the government's budget (NHDP, page 00). This will make it possible to consider ongoing funding needs that arise from the need to maintain the esults obtained from the funding provided by various technical and financial partners, including Gavi.

fter the grant has come to an end, these new financial resources are sufficient to fund the activities focused n strengthening human resources as well as missions and other "soft" activities.

the country requests recurrent activities, describe steps to reduce further reliance on Gavi funding for recurrent osts.

o ensure viability of the HSS2 programme, its activity target initiatives are addressed in the NHDP. This will acilitate sustainability of the results achieved as a result of the programme's implementation. Implementation ill also be accompanied by a budget line item that will be funded annually through a contribution to the overnment's budget. It will cover the costs of recurring activities and support measures required to develop ew strategies or activities introduced by the HSS2 grant. Specifically, these will include compensation for ontract workers and the wider use of incentives for delegated tasks.

rovide a summary of the country's policy and approach to sustainability.

he line item in the budget representing the government's share during the programme implementation period ill be used as a financial contribution to ensure sustainability of the results obtained with Gavi's support. It will e consolidated by financial resources to be mobilised within the framework of the NHDP's recommended pproach. The approach is to gradually increase the funds devoted to health within the government's budget, eplacing the external funding currently being injected into the sector.

his approach is in perfect alignment with the government's policy on reducing the country's dependence on xternal assistance.

should also be noted that the sector policy on human resources focuses on recruiting a significant number of octors and paramedical professionals every year to satisfy new needs, replacing those who are retiring or who re contract workers currently being used by FTPs in the sector like Gavi.

is within this framework that a school of medicine has been created. The school has begun graduating octors. In addition, there has been an increase in the number of public health schools providing training to aramedical professionals. There are now five instead of only one and they are spread throughout the country.

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

19. Implementation arrangements (2-page maximum)

Describe the planned implementation arrangements

Implementation of financial management activities and procedures for the Gavi/HSS2 grant is similar to that used to manage the HSS1 grant reprogramming submitted on 30 May 2016. It will be carried out according to the following governance, coordination, and monitoring and evaluation mechanisms.

1. Steering

Steering implementation of the action plan will take place under the leadership of the Minister of Health through the National Steering Committee for the NHDP (NSC-HS) that was created by Order no. 202/MS on 6 February 2012. This order addressed the creation, organisation and operation of the entity charged with steering, coordinating and monitoring implementation of the National Health Development Plan (NHDP).

The NSC-HS has final decision making power. Its general mission is to supervise, coordinate, endorse and monitor the implementation of the national health development plan and, specifically to (i) endorse and monitor operational plan execution and (ii) approve the operational action plan balance sheets.

The NSC-HS is chaired by the General Secretariat of the Ministry of Health and made up of national-level s representatives of the ministries concerned, the FTPs, the National Executive Secretariat for the Prevention of Al the president of the Mauritanian Association for Public Health, 2 representatives from civil society, 1 representa from the private medical sector, and 2 representatives from local governments. The steering committee is chaire the General Secretariat of the Ministry of Health and is scheduled to meet once every quarter in ordinary ses plus as many extraordinary sessions as are needed can be convened by the chair.

The committee receives support from the technical committee whose mission is to contribute to the preparation of technical work related to implementation of the National Health Development Plan. The technical committee also keeps up to date on implementation of recommendations made by the steering committee. The technical committee makes technical proposals to the steering committee and can also designate specific sub-committees as needed via a service note from the chair.

2. Project coordination and management:

- at the national level, by the Directorate of Planning, Cooperation and Health Information Directorate (DPCIS) that will actually lead the national process, under the authority of the NSC-HS and the ICC;
- at the regional level, by the Directorate of Regional Health Action (DRAS) under the authority of the wilaya (regional) council for socio-health development. This committee is chaired by the Wali (Governor of the wilaya;
- at the moughataa (prefecture) level, by the moughataa management team under the authority of the moughataa socio-health development committee and chaired by the hakem (prefect).
- at the health facility level, by the management committees including hospital boards and the boards of independent establishments, in compliance with hospital reforms and governance strengthening within the sector.

These committees are made up of leaders that are integral to the process of bringing together governmental entities, civil society organizations and associations, private health sector participants and FTPs toward the goal of making decisions together on all questions related to health including funding for health system strengthening under Gavi/HSS2.

3. Programme execution and responsibilities

Responsibilities for implementing programme activities involve the entities noted below:

- Leadership for planning, cooperation and health information, in collaboration with the DAF, ensures (i) monitoring of the implementation of activities being funded by Gavi/HSS2, (ii) preparation of quarterly reports on outcomes achieved, (iii) coordination of Gavi support with other activities and programmes within the healthcare system, and, (iv) preparation of the annual progress report for Gavi's review.
- the Directorate of Financial Affairs (DAF) ensures (i) financial management of Gavi/HSS support, (ii) monitoring the implementation of the activities for which these funds are to be used, in collaboration with the Directorate of Basic Health Services, and, (iii) preparation of quarterly technical and financial reports.
- the head physicians in the moughataas concerned implement the programmed activities for their respective moughataas in the field.
- The general inspectorate for health services, within the framework of its missing of internal audit, conducts periodic audits on the use of Gavi funds.
- the Directorate of Human Resources is involved in the implementation process for Gavi funds as they relate to human resources and capitalises on experiences to apply them in general to other ZCIs.
- civil society organisations (CSOs) directly carry out the activities assigned to them in the action plan.

4. Annual planning cycle

Within the framework of Gavi/HSS2, an action plan will be conducted each year to facilitate activity implementation and it will target those responsible for activity execution. Annual planning enables the sector's annual action plan and the cMYP to avoid duplicating Gavi activities. This annual planning of Gavi/HSS2 activities also addresses quarterly supervision and an external audit that is to take place at mid-term and again at the end of the project.

Furthermore, technical assistance is required for grant implementation and is scheduled.
This support is justified by the fact that managers from the DPCIS and other Ministry of Health directorates who are involved in grant implementation (and whose mission covers the entire country) will not be able to devote a significant part of their schedule to the Gavi ZCIs.
The expert recruited to support the DPCIS will be able to directly coordinate, execute and monitor the activities in the programme's action plan. This will lighten the system by avoiding the creation of a management unit to implement the grant.

Lessons learned from the implementation of the HSS1 grant have led to a focus on using the HSS2 grant for (soft) activities that are easy to execute. A management unit is not being used for the following reasons:
- Its operational costs have been judged to be too expensive in relation to the amount of programme funding
- Setting up this unit and training its staff will delay execution of the programme's activities
- The existence of a unit dedicated to a programme adds to administrative overhead and goes against the sector policy that focuses on strengthening the sectoral approach instead of a vertical project approach.

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

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

20. Participation of Civil Society Organisations (CSOs) (2-page maximum)

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

CSOs participation in the implementation of this grant will take place in two ways:

1. As a participant that is entirely separate from the implementation monitoring entities (NSC-HS and TC)
2. As those who execute the activities and particularly activities that are related to raising awareness and social mobilisation. Within this framework, priority will be given to CSOs that operate in the ZCIs.

   Toward the goal of transparency, CSO selection will be made through an appeal for those interested.

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

21. Risks and mitigation measures (2-page maximum)

If available, provide Attachment no. 35: Health sector risk assessment If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	***PROBABILITY*** ***(high, medium, low)***	***IMPACT*** ***(high, medium, low)***	***Mitigation Measures***
Objective 1: By September 2022, at the national level, strengthen the availability of competent human resources in the ZCIs and coordinating entities.			

Institutional Risks: **Weak involvement of regional and local managers in monitoring grant implementation**	Average	High	✓ Integrating the DRASS into the national monitoring committee ✓ Integrating the head moughataa physicians into the technical committee
Operational Risks: **Low availability of health workers in the country's interior**	Average	Medium	✓ Offer a remote incentive to motivate staff to remain in remote areas ✓ Contract with health workers looking for employment
Planning and Performance Risks: **Remote incentive payments for being paid irregularly**	Low	Low	✓ Integrate remote incentive payments into the credits assigned, managed directly by the moughataa health districts
Overall Risk Rating for Objective 1	Average	Low	***Regulatory administrative provisions noted above***
Objective 2: By September 2022, improve community participation and financial and technical transparency within the ZCI health systems			
Institutional Risks: **Functional nature of the steering entities and grant management**	Average	High	✓ Create regulations to define how the entities steering the sector will operate and how the grant will function
Fiduciary Risks: **The lack of financial management procedures** **Poor competency in financial management in the moughataas**	Average	Medium	✓ Develop and validate a financial procedures manual ✓ Train those responsible in ZCIs on procedures management
Operational Risks: **Difficulties of accessing all of the population with health activities and, in particular, those related to immunisation and maternal health**	Average	*Medium*	✓ Plan outreach and mobile activities to access populations that are not covered by the fixed strategy ✓ Add a budget line item to the government's budget that provides the moughataas with the fuel and staff incentives needed to carry out mobile and outreach activities
Planning and Performance Risks: **Weak planning mechanisms and poor monitoring performance**	Low	Low	✓ Introduce an annual planning mechanism and performance monitoring that will enable an assessment of the past year and lessons learned as well as set objectives to be reached for the coming year.
Overall Risk Rating for Objective 2	Low	Low	***Regulatory administrative provisions noted above***
Objective 3: By September 2022, in the ZCIs, strengthen basic health service coverage including immunisation, using the RED approach			

Institutional Risks: **Lack of a list of indigents who will benefit from free healthcare**	Low	Low	✓ Require certificate for indigence issued by the municipalities from individuals eligible for free healthcare
Fiduciary Risks: **Lack of baseline calculation for offering free healthcare at the various health facilities**	Low	Low	Develop procedures that detail the rates of services that are subject to being offered at no cost (free)
Operational Risks: **Community organisations that are not functional**	Low	Low	Re-activate community organisations and assign them tasks for monitoring the implementation of operational activities
Planning and Performance Risks: **Risks linked to planning and health facility performance monitoring to take into account aspects related to use of services**	Low	Low	Put in place use of service indicators and have them routinely input into information system
Overall Risk Rating for Objective 3	Low	Low	***Regulatory administrative provisions to be created***
Objective 4: By September 2022, increase the use of health services by stimulating demand.			
Institutional Risks: **Low involvement of CSOs in monitoring grant implementation**	High	Medium	✓ Involvement of CSOs in the grant monitoring committee,
Operational Risks: **Low BCO competency**	Low	Low	Train BCOs in the ZCIs on the channels to be used for raising awareness and on social mobilisation
Overall Risk Rating for Objective 4	Low	Low	***Regulatory administrative provisions to be created and related activities planned in the programme***
Objective 5: By September 2022, strengthen monitoring and evaluation and epidemiological surveillance capacity in the ZCIs and at the national level			
Institutional Risks: **Absence of integration of data into various sub-systems within the NHIS database**	Low	Low	Put an integrated information system in place by migrating from Maurisis to DHIS 2
Operational Risks: **Lack of competency of the MCMs and the chief post nurses in monitoring and**	Low	Low	Strengthen the competency of those responsible for monitoring and evaluation at the operational level

evaluation			
Planning and Performance Risks: **Lack of monitoring and evaluation mechanisms**	Low	Low	✓ Develop an NHDP monitoring and evaluation plan ✓ Implement an efficient mechanism for monitoring grant implementation that measures annual programme performance and provides for timely corrective measures to be implemented
Overall Risk Rating for Objective 5	Low	Low	***Regulatory administrative provisions to be created and related activities planned in the programme***
(Add more rows for additional objectives as required)			
***Pooled fund** applicants are required to provide any risk mitigation plan under the sector wide/pooled funding mechanism.*			

22. Financial management and procurement arrangements

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

The budget for the grant annual action plan is approved on an annual basis by the NSC-HS and transmitted to the DAF for activity execution according to the national procedure for doing so. Procurement is made in compliance with the provisions of the public procurement code. Technical entities initiate activities, within their individual areas of expertise. For activities carried out at the local level, sub-accounts are opened in the name of the moughataa health districts to which operational activity funds are received. Accounting for these funds is transmitted to DAF to be verified and archived.

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

The main constraint of the management system was made evident during Gavi/HSS1. It is cumbersome programme implementation procedures.

To avoid this impediment to implementing the new programme, we have avoided procurement and activities that require a long process.

It should also be noted that the activities targeted by the programme can be easily carried out and do not require a long process.

Because of lessons learned from the implementation of Gavi1/HSS, the programme's coordination structure will be strengthened through the use of long-lasting technical assistance for the implementation of a monitoring committee. The committee will bring together the entities involved in implementation and the relevant FTPs (UNICEF and WHO).

Some of these activities focus on strengthening the competencies of national and peripheral entities.

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

*Provide **Mandatory Attachment no. 7**: Detailed two-year Procurement Plan*

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

Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	BounaOuld El Kotob, Tel. +222 36 30 75 26 Email: belkotob@yahoo.fr
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES/~~NO~~
3. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • For ongoing grants from Gavi and other development partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion)	• Gavi 2011 support for health system strengthening in the amount of US$ 2,774,366 • Management of the funds from this grant was conducted according to national procedures with an account in a primary bank that was jointly accessible by the General Secretariat and the Ministry's DAF. Sub-accounts were opened in the name of the Moughataa Health Centres in the ZCIs to receive funds for the activities to be carried out by the moughataas concerned. • Difficulties in implementing the grant include cumbersome procurement procedures and the type of some of the activities initially programmed.
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	The health sector recently created a baseline for supervision. It outlines supervisions per level as follows: national-level supervision (the relevant technical directorates: DPCIS, DSBN, DAF, DHR, etc.) of the regional level: twice per year regional-level supervision (DRAS management team) of the districts (moughataas): four times per year moughataa-level supervision (moughataa management team) of the operational level (HC and HO): 6 times per year. Supervision reports will be submitted to the sector steering committee (NSC-HS) via its technical committee and the technical monitoring committee for the Gavi/HSS grant. The NSC-HS has final decision making power. The NSC-HS is chaired by the General Secretariat of the Ministry of Health and made up of national-level staff, representatives of the ministries concerned, the FTPs, the National Executive Secretariat for the Prevention of AIDS, the president of the Mauritanian

	Association for Public Health, 2 representatives from civil society, 1 representative from the private medical sector, and 2 representatives from local governments. The steering committee is chaired by the General Secretariat of the Ministry of Health and is scheduled to meet once every quarter in ordinary session plus as many extraordinary sessions as are needed can be convened by the chair. The decisions it makes are voted unanimously or by a majority of its members.
5. Who will be responsible for annual planning and budgeting for Gavi/HSS?	Planning and budgeting are coordinated by DPCIS.
6. What is the planning & budgeting process and who has the responsibility to approve the Gavi/HSS annual work plan and budget?	Gavi/HSS planning will take place within the framework of the sector's annual planning process. This process begins with strategic guidelines developed by the planning leadership and that are endorsed by the sector steering committee. Per the strategic guidelines, each DRAS supervises the annual planning process for the operational facilities (HOs and HCs). These are then consolidated at the moughataa level and transmitted to the DRASS for the development of the wilaya action plan. The wilaya plans are transmitted to the programme leadership who collects these plans from the department's facilities, consolidates them, and integrates them into the annual work plan for the sector. The latter is then endorsed by the sector's national steering committee. The various facilities are required to draft only one annual integrated plan.
7. Will the Gavi/HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES/~~NO~~
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to the programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	Gavi funds are housed in a primary bank in local currency. The account for this grant is accessed through dual signature from the GS and the DAF.
9. Will Gavi/HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	The Gavi funds are housed in a primary bank in an account in the name of the Ministry of Health.
10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	This account is reserved for Gavi funds only
11. Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc. If YES, please describe how fund transfers will be executed and controlled. State by what time of year (month/quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES/~~NO~~ (If YES, please describe) In addition to the main account, sub-accounts are opened in the name of the moughataas, for activities carried out at the local level. Funding the [sub-accounts] will occur at the request of the executing entity, per the annual action plan that has been endorsed and after justification of amounts previously allocated.

Procurement	
12. What procurement system will be used for the Gavi/HSS programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	Procurement with funds and this grant will take place in compliance with the provisions of the public procurement code.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Gavi/HSS2 grant activities are focused on activities that do not require significant procurement.
14. What is the staffing arrangement of the organisation in procurement?	There are procurement agreements with UNICEF and WHO for specific acquisitions (vaccines, items related to the cold chain, equipment for specific diseases).
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES/~~NO~~
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES/~~NO~~ (If YES, please describe) The public procurement code includes clauses that define the rights and conditions for registering complaints and the recourse available in relation to the procurement of goods and services.
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES/~~NO~~ (If YES, please describe) There is a procurement regulatory authority. It is an independent entity with members from the public and private sectors and civil society. Its mission is to address disputes and implement sanctions from the various procurement commissions. This authority guarantees efficient resolution of disputes related to procurement.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	The programme uses national financial and accounting procedures
19. What accounting procedures will be used for the Gavi/HSS programme? (Is there a specific accounting software or a manual accounting system?)	The programme will use the same accounting system procedures used by outside funding entities (World Bank, AFD, etc.). The accounting software TOMPRO is used
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Financial reports are produced quarterly and submitted to the sector's national steering committee and to the programme's monitoring committee

Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial	~~YES~~/NO

Management operational procedures?	
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi/HSS.	YES/~~NO~~ (If YES, please describe) The General Health Inspectorate will annually audit the programme.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES/~~NO~~ The NSC-HS receives the programme's internal audit reports, develops a plan for implementing their recommendations and ensure that this is monitored.
External audit	
24. Are the annual financial statements to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[1]	YES/~~NO~~ The financial statements will be audited by the General Health Inspectorate
25. Who is responsible for implementing audit recommendations?	The Minister of Health

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