



**Proposal from Chad  
for GAVI Alliance Support  
For Health System Strengthening (HSS)**

**REPROGRAMMING OF INTERVENTIONS  
FOR THE PERIOD FROM January 2013 to June 2014**

**September 2012**

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## Abbreviations and acronyms

<b>ARI</b>	Acute Respiratory Infection
<b>BCG</b>	Bacille Calmette Guérin
<b>BELACD</b>	Research and Liaison Office of Charitable Activity Development
<b>CCSS</b>	Health Sector Coordinating Committee
<b>CG</b>	Management Committee
<b>CNCARS S</b>	National Coordinating and Support Committee for Health System Strengthening
<b>COGES</b>	Management Committee
<b>COOPI</b>	Italian Cooperation
<b>COSAN</b>	Health Committee
<b>CPE</b>	Prevention Consultation for Children
<b>DACSI</b>	Division of Support, Coordination and Data Processing Monitoring
<b>DSIS</b>	Health Information System Division
<b>DSR</b>	Regional Health Delegation
<b>DWB</b>	Doctors Without Borders
<b>EEMET</b>	Entente des Eglises et des Missions Evangéliques du Tchad
<b>EOC</b>	Emergency Obstetrical Care
<b>GDP</b>	Gross Domestic Product
<b>GTZ</b>	German Cooperation
<b>HD</b>	Health District
<b>IEC/BCC</b>	Information, Education and Communication/Behaviour Change Communication
<b>INN</b>	International Non-proprietary Names
<b>LDC</b>	Least Developed Countries
<b>LLITN</b>	Long-lasting Insecticide Treated Mosquito Net
<b>MCD</b>	Chief District Physician
<b>MDG</b>	Millennium Development Goals
<b>MTEF</b>	Medium-Term Expenditure Framework
<b>MV</b>	Measles vaccine
<b>NPRS</b>	National Poverty Reduction Strategy
<b>PCA</b>	Drug Procurement Clearinghouse
<b>PCA</b>	Complementary Package of Activities
<b>PMA</b>	Minimum Package of Activities
<b>PNDS</b>	National Health Development Plan
<b>PNS</b>	National Health Policy
<b>RED</b>	Reach Every District
<b>RMA</b>	Monthly Activity Report
<b>SAASDE</b>	African Acceleration Strategy for Child Survival and Development
<b>SECADE V</b>	Catholic Development Relief
<b>SIA</b>	Supplemental Immunization Activities
<b>UNICEF</b>	United Nations Children's Fund
<b>WB</b>	World Bank
<b>WHO</b>	World Health Organization
<b>WPV</b>	Wild Polio Virus

## Summary

The 2007-2015 National Health Policy Report, the situational analysis of the 2009-2012 National Health Development Plan (PNDS) and the 2008-2012 Complete multiyear Plan identified four major principal constraints that are bottlenecks and prevent increasing and maintaining immunization coverage.

They are: (i) poor human resources; (ii) a poor health information system; (iii) frequent stockouts of essential drugs and medical consumables, including vaccines and immunization materials; and (iv) deficiencies in the organization, coordination and management of health services.

To address these constraints, in 2008 the MSP submitted a proposal to the GAVI HSS fund to contribute to strengthening and maintaining immunization coverage for children. The GAVI board of directors accepted this proposal in 2008. Implementation did not occur until 2009 with the first disbursement.

There were difficulties during the first year of implementation of the proposal because expenditures were scheduled for the second year but were executed in the first disbursement tranche. The situation resulted in the suspension of funding. A financial and managerial audit was conducted in 2010. Both parties accepted the recommendations of this audit: MSP and GAVI, and implementation began. The delay in implementing the proposal and the change in certain contextual components in the country led the Ministry of Public Health to reprogram the interventions.

The purpose and expected results of the reprogrammed proposal are the same as in the initial one: *contribute to reducing morbidity and mortality caused by vaccine-preventable diseases by extending the SASDE and RED in ten Health Districts by the end of June 2014 to increase and maintain immunization coverage for DTP3 at 95% and at 95% for TT2 in pregnant women in the 10 districts selected in the proposal.*

The specific objectives remained unchanged: (i) *strengthen the 10 districts with skilled and motivated employees by the end of June 2014;* (ii) *make the drug and medical products supply and management system efficient, including vaccines, in the health facilities of the ten Districts by June 2014;* (iii) *strengthen the organization and management of health services in the 10 Districts and 6 entities at the central level by June 2014.*

The reprogrammed proposal will cover the same Districts as the previous proposal. It will support the 10 Districts identified by providing support to the different levels of the health system by attacking the obstacles to increasing and maintaining immunization coverage, in particular the poor access to immunization services and their low rate of use.

At the central level, operating and supervision support will be provided to the MSP Secretariat General, to the Office of the Inspector General, and to 4 technical departments.

Through these units, the MSP intends to strengthen immunization interventions by: (i) preparing and implementing management tools, producing reliable health information, and monitoring activities at every level; (ii) supporting the organization of employee supervision missions and the management of drugs and medical products, including vaccines; (iii) strengthening the cold chamber at the central EPI; (iv) strengthening the system for shipping vaccines to the Health Delegations; and (v) strengthening employee motivation at every level.

At the intermediate level, there are plans to strengthen the organizational and technical capacities

of the 8 DSRs so that they are able to prepare and implement their regional health development plan. Emphasis will be placed on: (i) providing management training for the health services and financial management teams, and providing them with fuel for the integrated supervisions; (ii) improving the management capacities of 8 regional supply pharmacies by training the managers; (iii) ensuring a steady supply of drugs; and (iv) strengthening the regional health information system.

Emphasis will be placed on the following at the District level: (i) management capacity building for the ten district management teams by putting in place management tools for improving District organization and management; (ii) training these District teams in management, organizing monitoring and planning, and collecting and analysing SIS data; and (iii) strengthening the logistical capacities of the teams so that they can carry out integrated supervisions and monitor the interventions in the health centres and hospitals.

The following are planned at the health centre level: (i) train the employees of 100 health centres in IMCI+, EPI+ and PNC+; (ii) put in place drug management tools and guidelines; (iii) provide drugs and vaccines to the 100 health centres; (iv) provide the health centres with solar refrigerators; (v) provide the 100 health centres with motorcycles for the advanced strategies; and (vi) provide support for reorganizing the health committees and develop links with the communities by engaging with the health committees and community health workers for managing health centre immunization activities.

In the long run, the expected results of these actions are: the health system of 10 Districts will be strengthened as follows: (i) 10 Health Districts strengthened in terms of motivated health care personnel, with the required quantity and quality; (ii) COSANs have essential drugs and medical products, including vaccines; (iii) the Districts and COSANs will be equipped with cold chains; (iv) and the organization and operation of 10 Health Districts will be strengthened.

The reprogrammed proposal spans a period of 18 months, from January 2013 to June 30, 2014.

The total amount of funding to be mobilized for implementing and monitoring this reprogrammed proposal is: **See Excel budget file**

The management and evaluation system for implementing the reprogrammed proposal will be based on existing PNDS monitoring mechanisms, including meetings of management committees at the different levels; twice-yearly and yearly reviews; and monthly routine activity reports. The same indicators from the previous proposal will be used for this proposal: Six results and impact indicators were selected as follows: (i) DTP3 immunization coverage rates (77% in 2006 - 95% in June 2014); (ii) the number of districts that reach an  $\geq 80\%$  immunization coverage rate in DTP3 (23 HDs in 2006 - 44 HDs as of the end of June 2014); (iii) Mortality rate of children under five years of age (191 per 1,000 in 2004 - 64 per 1,000 in June 2014); (iv) the number of health centres that have been visited at least six times in the last year, during which a quantified checklist was used (24 in 2006 - 100% in June 2014); and (v) the number of health centres with skilled health care workers in the required number and present in the Responsibility Zone at least 10 out of 12 months (no data in 2006 - 80% in June 2014); and (vi) the average number of stockout days of ten essential drugs in the health centres in the quarter ended (no data in 2006 - 3% in June 2014).

The coordination and monitoring of the implementation of this proposal were modified slightly to improve monitoring and implementation in accordance with the recommendations of the audit report. The management committee was replaced with a technical committee (TC) that was put in place by the Ministry of Public Health at the different levels of the health system; it will be retained but its configuration will be improved.

At the central level, the Director of Planning chairs the technical committee, and a WHO official will second him.

The management and monitoring of proposal implementation will be incorporated into the Inter-agency Coordinating Committee (IACC) to implement the recommendations of the audit report. The IACC thus replaces the CNCARSS to strengthen transparency in decision-making and resource management.

## **Part 1: Reprogramming process for the proposal**

### **1 Context:**

In 2008 the Government of Chad submitted a HSS proposal to increase routine immunization coverage. Once GAVI approved it, the country obtained the first disbursement of US\$ 707,000 in 2009 for the activities scheduled for 2008, the first year of the plan.

During implementation, issues involving ineligible health expenditures emerged, such as the purchase of vehicles in the first year for the Health Districts, scheduled for the second year. These problems caused GAVI to suspend the funding in 2010.

At the request of the Government of Chad, GAVI performed an external audit in 2010, which culminated with relevant observations that were incorporated into the aide mémoire, which both parties signed in May 2012.

The recommendations from the audit are currently being implemented; these include opening a new account in March 2011, appointing two new signers (the Secretary General of the Ministry of Public Health or his assistant if he is not available, and the WHO Representative or, if he is not available, the WHO Administrator), and appointing a new official in charge of coordinating health system strengthening activities with GAVI funding.

It should also be stressed that Chad's epidemiological context over the last three years, with socio-health emergencies, was not favourable for implementing health system strengthening activities. In effect, the country experienced:

- i) Repeated epidemics of cholera, meningitis, measles, polio and Guinea worm, affecting 19 of the country's 22 regions;
- ii) A major influx of refugees from the North, East and South of the country, due to conflicts in neighbouring countries, as well as displaced persons from Eastern Chad for reasons of insecurity.

These problems led the country to focus its efforts on solving the problems, to the detriment of health system strengthening. This situation affected all the components of the health system, and immunization activities in particular.

Moreover, the MSP began the process of preparing a new national health development plan (PNDS 2). This process aims to be inclusive and began by preparing 22 regional health development plans with the participation of all the stakeholders at the regional and central levels. Capacity building for the facilities to increase and maintain immunization coverage is among the actions maintained in the PRDS documents.

Finally, the Ministry prepared and adopted a new complete multiyear plan (CmYP) to cover the 2013-2017 period.

In this context, this proposal will take into account the weaknesses of the immunization system, and in particular the low immunization coverage rate as well as the high dropout rate.

### **Reprogramming of activities from 2013 to 2015:**

At the GAVI HSS and Global Fund peer review proposal workshop held in Harare, Zimbabwe from November 29 to December 2, 2011, and following the conversation the Chad team had with the GAVI and WHO/HQ team, it was decided that Chad would reprogram the activities of the first proposal for the period from July 1, 2012 to December 31, 2013 (18 months), by scrupulously observing the following instructions:

- Maintain the previous objectives;
- Modify the activities;
- Remain within the envelope of the outstanding balance of the initial financing;
- Ensure the feasibility of the reprogrammed activities and compliance with the procedures;
- Consider GAVI technical support missions to finalize the reprogramming;
- Plan teleconferences with the GAVI Secretariat, WHO and UNICEF.

The current reprogramming of the activities takes into account the decisions of the Harare meeting, as well as and most especially the **recommendations of the Independent Review Committee of July 2012**. This reprogramming spans the period from January 2013 to June 2014 for the following reasons:

- The new national health development plan (PNDS2) and the complete multiyear plan of the EPI (CmYP) cover the period from 2013 to 2017;
- The regional health development plans (2013-2015) are prepared and have been validated; The CmYP was evaluated in May 2012 under the external review;
- PNDS1 is now being evaluated;
- The compact (pre-pact), a type of mutual commitment between the Government and the partners regarding a few critical bottlenecks that interfere with system performance, was signed in November 30, 2011 in N'Djaména. It covers the period from June 2011 to May 2013 and is a tool for implementing the current PNDS with an extension of 6 months.

The process of preparing this reprogramming is coordinated by currently existing bodies during the execution of the first proposal.

## **2 Coordinating bodies**

### **2.1: Technical Committee (TC)**

The TC was established by Ministerial Order No. 141/PR/PM/MSP/SE/SG/DGRP/DP/07 of July 4, 2007 to coordinate the preparation of and technical support for the reprogrammed proposal (**Annex 1**). It has been operational since 2007 and reports to the IACC, which coordinates and monitors the implementation of the reprogramming.

The TC met twice during the proposal reprogramming period. The principal outcomes of these meetings are:

- . Preparation of draft 1 of the reprogramming (January 13 to 16, 2012);
- . Finalization of the reprogramming document and the Annual Status Report (the two sets of minutes of these meetings are attached as an annex).

## 2.2 Inter-agency Coordinating Committee (IACC)

The Minister of Public Health chaired the IACC. It met once, on May 11, 2012 in N'Djaména. The minutes of the meeting are attached (Annex 1). At the meeting the IACC validated the first reprogramming document.

### 2.3 General roles and functions:

1. The Technical Committee is responsible for monitoring the progress of reprogramming in accordance with the roadmap and for providing technical support.
2. The IACC's role is: (i) to provide general guidance for drafting the proposal; (ii) to mobilize the resources to support the drafting, validation and adoption of the reprogramming proposal; (iii) to validate and adopt the proposal; and (iv) to send the proposal to the GAVI secretariat.

During the reprogramming process, meetings are organized regularly with the Technical Committee to present the different parts of the first draft in preparation. To this end, the parts that are prepared are sent to each technical committee member 3 days before the meeting. Next these parts are presented to the Technical Committee members during the committee meetings. A roundtable is held so that participants can give their opinion of the document. The observations on the document are recorded by the drafting group reporter and are incorporated. The first draft was reproduced for the Technical Committee members and distributed 3 days before the technical validation meeting. During the validation meeting, the Planning Director presented the document. The Technical Committee members in attendance examined the document page by page. Observations on the substance and form were added to the first draft. The document validated by the Technical Committee was approved and all IACC members adopted it under the chairmanship of Dr. MAMOUTH NAHOR NGAWARA, Minister of Public Health, IACC Chairman.

Among the partners and IACC members that approved and adopted the reprogrammed proposal, there were: (i) the Government (Ministry of Public Health, Ministry of Finance and the Budget) and the group of the United Nations system (WHO and UNICEF).

## Part 2: General country information

### 2.1: Most recent socio-demographic and economic information about your country<sup>1</sup>

Information	Value	Information	Value
Population	9,564,400	GNI per inhabitant	USD 444.20*
Annual birth group	442,934	Mortality rate amongst children under five	191 / 1,000
Surviving infants**	445,513	Infant mortality rate	102 / 1,000
Percentage of GNI allocated to health	Not available	Percentage of government expenses on health	5%

\* estimate

\*\* *Surviving infants = infants still alive at the age of 12 months*

Indicator	Value	Year of information	Source of information
<b>Demographic information</b>			
Total population	11,868,985	2010	2010/MSP statistical



			yearbook
Number of live births	468,825	2010	HISD / DCAP
Surviving infants	436,778	2010	HISD / DCAP
Percentage of GNI allocated to health	NOT AVAILABLE	NOT APPLICABLE	
<b>Socioeconomic information</b>			
GNI per inhabitant	USD 444.20	2006	INSEED
Mortality rate amongst children under five	191 per thousand	2004	EDST2
Infant mortality rate	102 per thousand	2004	EDST2
Percentage of government expenditure on health	5.6%	2010	2011 General State Budget

## 2.2: Summary of the national health policy paper

Chad's socio-health situation is characterised by the prevalence of endemic and epidemic diseases. These diseases particularly affect women and children, the most vulnerable groups of the population. The problems include:

- Malaria
- Measles, tuberculosis
- Acute respiratory infections
- HIV/AIDS and diarrhoea
- Recurring meningitis and cholera epidemics
- Malnutrition.

According to a study on Emergency Obstetric Care (EOC) carried out in 2011 (Annex X) in the health facilities, haemorrhaging (33.98%) and post-partum infections (33.33%) are the leading causes of maternal deaths, followed by eclampsia/pre-eclampsia (10.84%), dystocia (6.47%) and complications from abortions (4.35%).

The level of HIV prevalence in Chad is 3.3%<sup>1</sup> amongst 15 to 49 year-olds. This level is higher than Niger's (0.87%) in 2003, but lower than Cameroon's (5.5%) in 2004. Its impact may worsen unless strong measures are taken to limit this scourge.

The level of literacy is low: 66% for men and 34% for women. At the primary level, the total enrolment ratio is 71.6%, of which 54.6% are girls and 88.3% are boys.

The 2011 UNDP Human Development Index places Chad 181<sup>st</sup> out of 185 countries and the country is ranked amongst the Least Developed Countries (LDC).

The assessment of the implementation of the national health policy (PNS) carried out in 2005-2006 and the national strategy paper on fighting poverty (Annex 2) revealed a weakness in the system's response to these health problems. It was noted that the population has poor access to health care services, the availability of these services, their use, coverage and quality. Furthermore, this analysis highlighted the under-financing of the health sector and a lack of management of mobilized resources.

To tackle this new challenge, the Ministry of Public Health, working with its partners, drew up a PNS covering the 2007-2015 period. This policy, which is the first element in a reform of the health sector,

<sup>1</sup> Seroprevalence survey,.... 2005.

focused on the development of the sector-wide health approach, was adopted on 4 May 2007.

The main issues raised were:

- The organization, operation and management of the sector,
- The provision of health care,
- Human resources development,
- Drugs,
- Health care financing.

Based on these shortcomings, the major strategic focuses in the health sector were drafted. The vision of health care development in Chad by the year 2015 is to improve the health of the population of Chad. This vision is part of the framework for achieving the Millennium Development Goals (MDGs) with a national poverty reduction strategy as an instrument for implementation.

The main objective of this policy is to guarantee the *population access to basic quality services to speed up the reduction in mortality and morbidity in order to contribute to achieving the MDGs by 2015.*

Seven specific objectives were decided upon in order to facilitate the achievement of this general objective:

1. Reduce maternal mortality from 1,099 to 275 deaths per 100,000 live births by 2015;
2. Reduce neo-natal mortality from 48 to 12 per thousand live births by 2015;
3. Reduce infant-child mortality from 191 to 64 per thousand live births by 2015;
4. Reduce the transmission of HIV and the impact of AIDS;
5. Control malaria, tuberculosis and other priority diseases (epidemic diseases, diseases to be eliminated and eradicated, emerging diseases and non-communicable diseases) and begin to reverse current trends;
6. Ensure better availability and the sound use of safe, effective, quality and affordable drugs for the people;
7. Ensure the availability of human resources of a good quality and quantity at all levels.

These objectives revolve around 6 strategic focuses: (i) strengthen the organization and management of the national health care system, including the private and traditional sectors; (ii) improve access to and the availability of quality health care services; (iii) strengthen the interventions against the main diseases; (iv) improve the provision of quality health care for women and children; (v) develop and properly manage resources for health, including drugs; and (vi) and develop a health partnership.

The National Health Policy will be implemented through a National Health Development Plan (PNDS). The PNDS was drawn up and adopted in 2009 and covers the period from 2009 to 2012 (Annex 3).

Health System Strengthening is an integral part of the PNDS, which is a tool to mobilize the efforts of all the stakeholders in the system to rise to the challenge of achieving the health MDGs by stressing accountability and the leadership of the Ministry of Public Health.

On May 16, 2011 the Government signed a general pact and a local pre-pact on November 30, 2011 (Annex 4) to facilitate the implementation of the PNDS.

The pre-pact emphasizes transparency in resource management. The different health stakeholders committed to the pact to support the implementation of the PNDS.

The Government made commitments in: (i) the allocation of the State budget to the health sector and the use of this budget; (ii) hiring health care workers and redeploying them in the health facilities; and (iii) the rational use of drugs and medicinal products.

**The sector partners agreed to support the Ministry of Public Health to evaluate PNDS 1**

## and to prepare the PRDSs and the PNDS2;

Shared responsibilities: coordination, supervisions, monitoring, and information sharing are listed in the pre-pact (annex).

The Regional Health Development Plans (PRDSs) were prepared in March 2012 and are used for the future PNDS (2013-2017).

Thus, the reprogrammed proposal takes all of these documents into account while being consistent with their strategic focuses as well as the monitoring and evaluation systems provided for in these documents.

The MSP mapped the partner interventions (Annex 5). This mapping will facilitate the coordination of partner interventions in the health sector. The recent reprogramming took into account the coverage of partner interventions in the Districts.

## Part 3: Situational analysis / needs evaluation

### 3.1: Recent evaluations of the health system<sup>3</sup>

Name of evaluation	Participating institutions	Areas / subjects covered	Dates
National Health Policy	MSP and Partners	Health	2007
PNDS	MSP, partners and civil society	Health	2009
Demographic and Health Survey (EDST 2)	Ministry of Planning and the Economy	Health	2007
Survey on consumption in the informal sector (SCOIS)	Ministry of Planning and the Economy	Household health and living conditions	2007
Report on SNRP 2	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	A report and at the same time a 2008-2010 action plan which targets the main priority interventions to be developed to contribute to the fight against poverty. These include the fight against HIV/AIDS, malaria, tuberculosis, pre-natal consultations and assisted births, and infant immunizations. Special emphasis is placed on the redeployment of human resources and other resources aimed at rural areas and areas that are difficult to access.	2007
Pre-pact	Validated in 2011	Health	2011
Pact	Signed in January 2012	Health Resources strengthening Technical support	
Mapping of partner interventions in the health sector in Chad	Now being validated		2011
Report on the evaluation of the costs of the MDGs	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	The objective of this report is to estimate the means required to achieve the Millennium Development Goals (MDGs) by 2015. The areas analysed are: HIV/AIDS, tuberculosis, malaria, and maternal and infant health. The analysis was carried out by a group of 3 national consultants.	2007

2007-2008 MSP emergency plan	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	The emergency plan is a plan that aims to develop 11 packages of priority and urgent interventions for 2007-2008. The PNDS will take over in 2009. The areas covered are: (i) human resources development; (ii) the unblocking of the National General Reference Hospital (HGRN) and the acceleration of hospital reform; (iii) coordination of the health interventions for refugees and displaced persons; (iv) Setting up a national health observatory; (v) streamlining the supply of drugs, reagents and medical consumables; (vi) strengthening the detection and response to epidemics; (vii) accelerating the achievement of the MDGs; (viii) accelerating the preparation of the PNDS; (ix) strengthening the leadership and management of the partnership; (x) develop workers' health; (xi) develop appropriate IEC/BCC strategies	2007
2007-2012 CmYP	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	This is a multi-year plan (2008-2012) to implement immunization. A situational analysis of the socio-health and economic context was conducted. The guidelines for action were defined and adopted to develop a programme to increase and maintain immunization coverage.	2007
2013-2017 CmYP	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	This is a multi-year plan (2013-2017) to implement immunization. It was prepared based on the analyses performed by the evaluation of the first plan.	2012
Roadmap to fight maternal and neo-natal mortality	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	Strategic document on reducing maternal and neo-natal mortality. It is based on the Millennium Development Goals (MDGs).	2007
Chad UNICEF cooperation review report	Ministry of Public Health, Ministry in charge of Planning, Ministry in charge of Social Action, UNDP, WHO, UNICEF, World Bank, European Union, UNFPA, French Cooperation	Cooperation programme between the Ministry of Public Health and UNICEF covering the 2006-2010 period. Its main objective is to contribute to reducing infant and infant-child mortality. Its main strategy is the development of the SAASDE.	2007
2008-2009 two-year cooperation between	Ministry of Public Health and the WHO	Cooperation program between the Ministry of Health and WHO for 2008-	2007

Chad and WHO		2010. Its aim is to contribute to the implementation of the national health policy by supporting the national programmes and strengthening the health system.	
Two-year cooperation between Chad and WHO 2010-2010	Ministry of Public Health and the WHO	Cooperation program between the Ministry of Health and the WHO for 2008-2010. Its aim is to contribute to the implementation of the national health policy by supporting the national programmes and strengthening the health system.	2007
SNIS evaluation report	Ministry of Public Health and the European Union	Contribute to revitalizing the Chad SIS by incorporating certain program indicators: PSLs, TB, malaria and activities related to maternal and child health	2011
Report on the evaluation of Chad's EONC needs in 2010	Ministry of Public Health, UNFPA, UNICEF, the WHO and AMDD	Contribute to updating the indicators on mother and child health	2011
External EPI review	Ministry of Public Health, UNICEF and the WHO	Evaluation of the operational and management components combined with an immunization coverage survey	2012

<sup>3</sup> Over the last three years.

## 3.2: Main obstacles to improving immunization coverage identified by recent evaluations

### 3.2.1 Health problems that mainly affect women and children

Protecting mothers and children is the main priority of the Government of Chad. However, despite efforts by the Ministry of Public Health, we note that the mother and infant mortality rate in Chad is still very high. This mortality is due primarily to defects in immunization whose indicators, which have fallen in the recent period and highlight the urgency of strengthening the health system.

#### A - Main problems affecting women

The maternal mortality rate, which in 1997 was 827 per 100,000 live births in EDST I, is currently 1,099 in EDST II in 2004. The main causes of this high number of maternal deaths is made clear in the roadmap for accelerating the reduction in maternal and neo-natal mortality in Chad (Annex 6).

- insufficient pregnancy monitoring;
- inadequate care during labour in case of complications;
- low contraception prevalence;
- poor diet amongst women;
- persistence of harmful traditional practices.

#### B - Main health problems affecting children

A child's health is also highly dependent upon the mother's state of health. According to the results of the EDST II (2004) and the PNDS, child health indicators are not encouraging:

- an infant mortality rate of 102 per thousand;
- an infant-child mortality rate of 191 per thousand, in other words, approximately one child in five does not reach their fifth birthday;
- 11% of children under the age of one are completely immunized;
- Nearly 90% of the children suffering from acute respiratory infections have not been seen by medical staff;
- 44% of children under the age of five do not sleep under a mosquito net;
- Nearly 60% of the children that have had diarrhoea have not undergone oral rehydration therapy;
- 41% of children suffer from moderate malnutrition and almost one child in five suffers from severe malnutrition.

Furthermore, for more than ten years, malaria, diarrhoea, Acute Respiratory Infections (ARIs), dysentery and malnutrition are still the main reasons for consultations amongst children under the age of 5; measles and neo-natal tetanus are amongst the most fatal diseases (Annex 7).

Despite immunization efforts, national coverage remains low and has never reached 90% (DTP3 83% in 2010 based on administrative data). The external evaluation of the EPI that was just conducted (in April 2012) provided important data on immunization coverage.

The frequency of vaccine-preventable diseases is due to the weak district health system (SSD). In fact, weaknesses in the organization and management of the health facilities, as well as a shortage of resources and drugs, limit access by women and children to health care services and weaken the efficiency and the quality of immunization activities carried out for these vulnerable groups. The result is that mother and child mortality is still particularly high in Chad.

This situation exacerbates the lethality of measles and neo-natal tetanus and ranks them among the most fatal childhood diseases. We also note the persistence of cases of the WPV with 13 cases of the wild poliovirus in 2011.

### **3.2.2 Obstacles related to the weak health system response**

Different recent evaluations have documented the obstacles related to the weak health system response that hampers immunization activities in some districts. These problems may be grouped under the following five determinants (availability, geographic accessibility, usage, adequate coverage and effective coverage) that are linked to the organization of health services, especially at the District level.

The analysis of these determinants causes bottlenecks to emerge for each one, and they affect the maintenance of and an increase in immunization coverage.

#### **A - Weaknesses related to the geographical accessibility and availability of health care services**

The theoretical coverage of the population by the health facilities is 74% (Annex 7). Meanwhile, this coverage is considerably below the actual coverage, which would only be a third of the theoretical coverage, and it restricts considerably the effectiveness of the interventions carried out by the District health system (SSD). Amongst the bottlenecks that impact the access and availability of services, we have:

(i) a lack of functional health centres

(ii) insufficient skilled human resources, which is one of the main reasons that limits the functionality of health centres according to health statistics from the Ministry of Public Health.

##### *a – Poor coverage of the population in health facilities:*

In 2010, of the 1,114 Responsibility Zones, 770 are functional (*by definition, a functional zone is one that has a health centre with at least one skilled worker, an infrastructure, and drugs*). The Responsibility Zones are divided into Zones A and B. The population of Zone A (radius of 5 km) has access to health services; by contrast, the population of Zone B (5 km and +) does not have easy access to services, and to preventive care in particular.

Advanced strategies are used as the means to improve coverage for the populations of the B Zones in health care. Unfortunately, less than a third of the health centres carries out advanced activities. This explains that a large portion of the population is not continuously covered by preventive activities, and by immunization in particular. The main reasons for the poor organization of the advanced strategy include: insufficient means of transportation, of the cold chain, skilled employees, and poor community participation.

##### *b- Human resources*

Human resources are important to provide a minimum package of activities (PMA) and a

complementary package of activities (PCA) and immunization in particular. In fact, the efficacy and efficiency of the use of inputs, such as drugs, equipment and information, depend on the existence and performance of the health care staff in the health facilities. The performance of this staff is in itself linked to their skills, whose determinants are the quality of their training, their availability, and their motivation.

The number of employees in the health centres is insufficient, and they are in charge of executing all the tasks in the minimum package of activities (PMA). Generally, one single skilled employee is responsible for promoting, preventing and treating the health problems of the entire population in a Responsibility Zone covering approximately 5,000 to 10,000 inhabitants.

This is the situation found in most of the health centres, particularly in rural areas or those that are difficult to access. This leads to having auxiliary nurses perform immunization activities and to operations paid for by the cost recovery system. These are also often requested to assist the person in charge of the health centre in certain procedures such as dressings, managing the details and stock of the pharmacy, or even consultations. The skilled employees are also sometimes forced to be absent for long periods to deal with their administrative documentation or their salaries in the capital city.

An analysis of the MSP health statistics in 2010 reveals a significant gap between the WHO standards and national coverage (1 doctor for 31,735 inhabitants compared to a standard of 1 per 10,000) (Annex 7). According to DRH data, the health sector has about 5,977 employees, all categories and all affiliations combined (public, private, faith-based, etc.). The breakdown of this figure shows that 36.5% of these professionals are in N'Djaména, which has only 8 to 9% of the nation's population, while 63.5% work outside the capital, in the provinces. Thus, medical staff is concentrated in the large urban centres to the detriment of rural areas. The disaggregation of the total percentage according to occupational category shows major inequities: 57% of physicians, 88% of physicians [sic] and 100% of dentists are located in N'Djaména, as well as 66.5% of nursing care technicians, 66.5% of nutrition technicians, and 100% of public health technicians. As a result, it comes as no surprise that the ratio of the number of inhabitants per physician is 1/4,967 in N'Djaména, while it is just 1/263,515 in the Batha region, 1/159,271 in Mandoul, 1/150,456 in the Lac region, and 1/140,739 in Hadjer Lamis.

In general terms, the findings that pertain to the issue of developing human health resources in Chad can be summarised as follows:

- A qualitative and quantitative shortage of staff characterised by: (i) a shortage of staff in the health centres and public hospitals; (ii) a seriously low skill level for staff, both for curative care as well as preventive and promotional care; (iii) a gender imbalance in health care workers: the ratio of the number of women to men is very low.
- Shortcomings in the management of health care staff *evidenced by*: (i) inadequate initial training compared to needs in the field; (ii) insufficient definition of the tasks and duties of the different provider categories; (iii) the uneven distribution of staff by the DSR between rural and urban areas, which generates a predominance of staff in the large urban centres and large hospitals; (iv) an absence of an employee career plan; (v) inappropriate planning of continuing training, both in terms of production as well as programming and coordination; and (vi) poor employee motivation.



In the context of implementing an appropriate response to the gaps in managing immunization activities, it is important here to stress the low rate of women in the medical and paramedical professions in Chad. In fact, of the 5,977 health care workers, 3,906 (65%) are men, and just 2,071 (35%) are women. Thus, we note a clear predominance of male workers, including in those categories in which we usually observe a high percentage of women, such as the nursing profession. In Chad, of the 799 registered nurses surveyed, just 30% are women. For the ATS and IB category of nurses, their number of women is only slightly higher at 36.5%.

Finally, even though all working midwives are women, there are only 243 of them, or 1 midwife for 10,466 women of childbearing age (WCBA). In the regions of Batha, Lac, and Tandjilé, no midwife positions have been filled. This situation is of grave concern in that Chad must meet the challenge of reducing maternal mortality, with a ratio of 1,099 deaths per 100,000 live births, according to EDST 2. More generally, and above and beyond obstetrics alone, there is reason for concern over the small number of women in the paramedical professions. Nurses (IDE, ATS, or IB), as well as registered midwives, are powerful leverage to have women take part in preventive and promotional activities, and immunization in particular. Their presence, contrary to that of men, is reassuring in that they are an asset to facilitate the cultural acceptability of the preventive and curative health care that is offered to women, especially in rural areas.

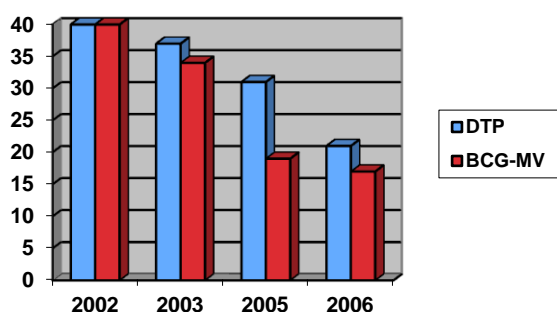
### **B – Weakness in the use and quality of health services**

In 2003, the survey on complete obstetric emergency care (COEC) revealed that few people were using health care services and maternal and infant health services in particular. The causes of this under-use were: (i) a poor perceived quality and technique in the services offered (mortality levels in hospitals are 4%); (ii) poor reception; and (iii) insufficient information, education and communication with users of the health services.

No structured study on the immunization dropout rate has yet been carried out to accurately determine the proportion of children lost by the system before having been fully immunized. Meanwhile, the comparison of the rates of BCG, MV and DTP clearly indicates that a large proportion of children have had at least one opportunity to come into contact with the immunization system, but have not continued with their immunizations up to the third dose of DTP (DTP3) (Annex 8). Dropout rates are estimated in Graph 1 below and show large gaps between DTP1 and DTP3 coverage.

The reasons for dropping out of immunization are quite obviously connected to the reasons for totally rejecting maternal and infant health services, as identified above. However, we should stress the consequences of poor reception and the negative sentiment of the people regarding the quality of the services offered in the public health centres. They result in lowering parent motivation as well as community involvement in routine immunization activities.

**Graph 1:** Change in Health District performance in terms of the dropout rate



**Source:** 2007 CmYP

**Graph 2:** Change in Health District performance in immunization coverage

[key]

Number of Districts with DTP3 equal to or more than 80%

Number of Districts with DTP3 between 50% and 80%

Number of Districts with DTP3 under 50%

**Source:** 2007 CmYP

These determinants reinforce the effect of factors such as the distance of families from care facilities (geographical accessibility) on the decisions households make whether or not to be immunized. It is also necessary to emphasize the fact that the low level of the people's involvement is a serious impediment to the use of health services, and immunization services in particular, and that the geographical accessibility barrier is high. Thus, despite community participation, officially instituted in Chad in 2001 in the health facilities, very few health centres have representative and functional health committees.

Finally, we should stress the low levels of integration and the continuity of services offered to the population, in particular maternal and infant health, which are a structural obstacle to the use of services. The strategy of integrated management of childhood diseases (IMCI) is in its infancy in the country (in certain Health Districts with the African Acceleration Strategy for Child Development and Survival/SAASDE). Moreover, coverage in Districts with health care staff trained in IMCI, drugs and organization is low and this limits the overall management of child health problems.

### **C - Weakness in coordination, monitoring and supervisions at various levels of the health system**

In addition to these obstacles, linked to a shortage of health care staff and the dysfunctional organization of services, the poor quality and quantity of supervisions are another weak link in Chad's health care system.

Poor logistics at District level and in the health centres does not facilitate supervisions or the sufficient supply of drugs. And yet, these supervisions are essential to strengthen the skills of the staff and their motivation, and to resolve the difficulties encountered in the health care

facilities.

According to the MSP's 2009 statistics, less than ¼ of Health Districts have vehicles to carry out supervisions of health centres. Furthermore, the Districts that do have vehicles carry out ineffective supervisions (no standardized supervision documentation and irregular missions).

Furthermore, poor organization in the Districts and Responsibility Zones limits the supervisory and monitoring capacities of health centres by the District management teams. The evaluation of the operability of the Health Districts in 2006 showed that less than 40% of the Districts were operational. In 2010, the number of operational Districts was 60 out of the 82 Health Districts in the country (Annex 7).

Finally, the necessary coordination among the different levels of the health system in the context of the essential strategic functions given to the central authorities of the department has not been implemented. Under these conditions, the ability to plan and program integrated supervision activities that involve all the programs that operate at the operational level, as well as all the local stakeholders, is decreased significantly.

### **3.3: Obstacles that are being handled in a satisfactory manner with existing resources**

The MSP has been or is making efforts to deal with the challenges caused by the fight against childhood diseases. They are: (i) the reform of the organization of the health care system, and in particular the reorganization of the operational level of the supply of care which, by decentralizing public-decision-making, gives the Health Districts autonomy as well as the powers and prerogatives through which the effectiveness of fighting diseases improves; (ii) the preparation of medium-term policy and strategy papers to facilitate the mobilization of resources to deal with health priorities; (iii) innovations introduced into the area of human resources development for health (HRH), or in the area of the public-private partnerships (PPP). These are areas in which the MSP has taken initiatives that demonstrate a strong commitment; and (iv) extending geographical coverage and availability by building health care centres and hospitals.

#### **3.3.1 Reform of the organization of health care in Chad based on the Primary Health Care Model**

Relaunched and expanded at the Ouagadougou SSP and Health System Conference, the Primary Health Care Approach provides an adequate framework for preparing, implementing and monitoring the GAVI HSS proposal. The current organization of the health pyramid provides a strengthened operational apparatus at the peripheral level through the creation of the Health Districts. Institutional and technical resources, as well as functional mechanisms combined with the existence of these Districts, can contribute effectively to removing the obstacles encountered in fighting disease. This pyramid system has three levels:

- a) The central level aims to define the national strategic directions, to mobilize and distribute resources, and control their use. This level includes 3 general departments and 8 technical departments, including the Reproductive Health and Immunization Department, to which the Immunization Division (EPI) and the Planning Division, which coordinates the drafting, implementation and monitoring of the GAVI HSS proposals, are attached. The organization of this department and its duties are

described in Order No. 100 on the organization and operation of the MSP.

- b) The intermediate level, known as the Regional Health Delegation (DSR), is tasked with carrying out the programming, supporting the implementation of and monitoring the interventions. There are 21 DSRs. Each DSR includes a regional health department, a regional hospital and a regional supply pharmacy (PRA). The purpose of the RSP is to supply and distribute drugs and medicinal products to the health care facilities. It is able to effectively support the supply/distribution process for vaccines and to contribute to making their operation sustainable.
- c) The peripheral level called the “Health District” is the operational level of the health system. These include 82 Health Districts, 60 of which are operational in 2010. Each District includes two levels: Level 1 consists of the Responsibility Zones. In each zone at least one health centre has been planned or built. In 2010, 1,114 Responsibility Zones were counted, 770 of which were functional. Level 2 includes a District hospital and a District Department. The District is the linchpin for the implementation of the national health policy. The communities organized in terms of Responsibility Zones into Health Committees (COSAN) take part in the drafting and implementation of the micro plan. These COSANs are directly involved in the management of the activities and resources through their Management Committee (COGES). Through the COSANs and the COGESs, community participation in fighting disease can and should take place. The institutions, procedures and mechanisms are thus in place and simply need to be used. They are in a position to make a powerful contribution to implementing immunization activities, especially through the opportunity offered to the populations to become actively and decisively involved in preventing the diseases that strike women and children and that are very often preventable.

Finally, the independence and autonomy acknowledged at the rational level, which are realized mainly by decentralizing the assignment of health care personnel, are an accomplishment that needs to be strengthened. As part of the decentralization process that has been implemented in the MSP, the central level is not authorized to directly assign an employee to a peripheral facility. The employees are seconded to the Regional Health Delegations which in turn assign them to the Health Districts based on priority needs.

An essential regulatory body also intervenes in assigning employees to the field to verify their relevance in terms of the priority needs of the regions and personnel standards. It is the Assignment Commission, created by an order of the Public Health Ministry (Order No. 757/PR/PM/MSP/SE/SG/DGRP/DRET/DGP/08 of December 11, 2008). All these reforms and innovations illustrate the Government’s resolve and the priority it places on measures to foster the extension of health coverage.

### **3.3.2 Initiatives and innovations that foster immunization in the area of human resources for health and PPP**

For the PPP, Chad has had a paper entitled “Health Sector Contracting Policy” since December 2001. The regulatory framework in Chad is very ambitious. It provides for delegating the public service mission not only to the health facilities, such as the hospitals and health centres, but also possibly to the Districts themselves. Recently, pilot experiments have been launched in the drug

sector, in which the management of regional pharmacies is entrusted to private bodies. However, and this is specific to Chad, there is the resolve and the spirit of openness in the authorities which, from the outset, has played an active role in contractual relationships by providing infrastructures and staff. The consensual climate of reciprocal trust between the Government and its faith-based partners (*Union Nationale des Associations Diocésaines/UNAD* and *Entente des Missions et Églises Évangéliques du Tchad/EEMET*) is seldom found to such a degree in similar reforms in Africa. Moreover, there is the fact that “de facto” contracting practices preceded by far the preparation of the Contracting Policy and its tools. The formal contracting process was thus preceded by largely informal cooperation, accepted by the Government and the MSP without reservation.

In effect, the role of the churches in health was scaled up starting in 1979. The faith-based health centres, created starting at that time, obtained immediate recognition from the Government. They have been on the health map since 1993 with the implementation of the District Policy. The Office of Research and Liaison for Charity and Development, or BELACDs, which are technical units in charge of managing the health centres for the churches when the Government makes them responsible for doing so, and all faith-based management structures involved in health activities, were legalized by the authorities in the decade that preceded the implementation of the CP. The District of Moïssala in the former health prefecture of Mandoul significantly illustrates PPPs in Chad. At first, the Sarh BELCAD was asked to renovate the public medical centre in Moïssala to set up a District hospital. This founding stage, which began in 1992, continues with the contractual delegation of the entire District of Moïssala to the Sarh BELCAD.

To be sure, the lag of roughly 30 years in the contracting relationships between the Government and the faith-based health sector highlights the effects that have ensued for the various health interventions. Specific programs such as the EPI have effectively profited from this partnership. In any case, the accessibility and availability of appropriate and quality services have increased for the target groups (mothers and children) of these programmes. Thus, there is a solid foundation of experiences and practices to be developed and intensified to increase immunization services coverage.

For human resources for health, the MSP faces a considerable challenge due to the highly unbalanced distribution of health care workers, and some categories are nearly non-existent in the regions and Health Districts. Such a context does nothing to improve the perceived quality of public health services. This hinders the appropriate provision of care for children and their mothers, and the management of this care surely suffers from such inequalities. Again, to stress the severity of the situation, of which a damning overview was given in the previous sections, we can note that of the 104 nursing care technicians available, 35 serve in N'Djaména, 13 in the RN HGs and H Lib, and 21 serve in administrative capacities in the central units. In other words, 2/3 of all nursing care technicians are unavailable for people who live in the interior of the country. The same is true for the 69 nursing care health assistants, 78% of whom, or 54 employees, are assigned to the capital city.

The MSP's response was to implement a strategy to decentralize provider training to bring them closer to the locations where they practice their profession. Known as Initial Decentralized Training, or FID, the purpose of this strategy, set up in the form of a project, was to train 620 technical health care workers in 5 years with training that lasted 2 years in the regions of Abéché, Moundou and Sarh. The objective of the FID was to respond to an urgent need of the peripheral health centres for nurses and to have them settle there, because the

recipients were to work for at least 4 years before asking to change the place of assignment. The project was completed in 2004. The assessment recommended making FID permanent because it is a strategy that provides the required nursing staff to the health facilities in a reasonable amount of time. Since the adoption in 2007 of Law No. 014/PR/2007 that established the Regional Health and Social Affairs Schools (ERSAS), the FID educational institutions were converted into regional health schools and given legal status and autonomous management. In addition to technical health care workers and birthing nurses, they are supposed to train registered nurses and registered midwives.

The FCJMG strategy (Complementary Training for Young General Practitioners) can be mentioned as well. To mitigate the lack of specialist physicians in district hospitals, the Ministry of Public Health, through Order No. 376/MSP/DG/DIRPLAF/DF/97 of March 14, 1997, established the FCJMG in the areas of surgery, paediatrics, medicine and district management. This is occurring through practical internships in the hospitals, followed by evaluations.

This is compulsory training that lasts about 10 months. Its purpose is to impart additional field knowledge to young physicians so that they are able to treat the emergencies that occur in the Health District hospitals. The results in the field were deemed conclusive. As of now, these physicians solve the priority health problems in the periphery. Through the FCJMG, the MSP has the means to improve the continuity of services and thus to respond to a demand expressed by the users. Mothers and children are satisfied with this innovation that increases the availability of medical resources that can be used to treat the complications of their specific diseases.

Finally, there is one important question, raised on many occasions by all the stakeholders in the health system, that the Government and the MSP have answered pertinently, although it is possible to further improve it by diversifying the approaches that are adopted. It is the issue of motivating the public health care providers. Neither Law 019/PR/99 of December 10, 1999, which establishes community participation in health costs, nor Decree No. 364/PR/MSP/2001 of July 18, 2001, on the organization of community participation in health costs, determine the share of revenue from cost recovery to be spent on motivating health care workers. Article 8 of Decree No. 364 simply provides that “partnership agreements between the Health Committees (COSANs) and the health centres shall determine the procedures for them to work together to manage and control the use of community participation funds.”

Only Order No. 362 on rate harmonization in health facilities addresses this matter. However, the ambiguity of the order, which provides for an amount equal to 25% of revenue collected, will be redistributed to the community health care facilities for motivation, and this has led to discretionary and diverse practices that depart from the legislators’ real intentions.

In the end, the Special Status of the Public Health Corps served as a basis for implementing a consensual and effective motivation policy. On June 3, 2011, following serious tensions between health-sector employees and the governmental authorities on the matter of compensation for public health care workers, a memorandum of understanding was signed by the Government and the Union of Social Affairs and Health Care Workers (SYNTASST). This memorandum provides for the full implementation of Decree No. 125/PR/PM/MFPT/96 of March 6, 1996 on the Special Status of the Public Health Corps, and Decree No. 903/PR/PM/MFPT/2006 of October 12, 2006, on the Special Status of the Corps of Health Sector and Social Affairs Civil Servants. All the premiums and bonuses provided for by the above-mentioned orders will be paid gradually over a period of 3 years, from 2012 to 2014.

In 2012, there are plans to pay the annual allowance for occupational hazards and the monthly allowance for austere zones (level-1 austere zones and level-2 austere zones). In 2013, the housing allowance and night guard allowance will in turn be included. Finally, beginning in 2014, the Government will pay the annual transportation allowance and responsibility allowance. A parity committee of 8 members was established to monitor and evaluate the Memorandum. However, above and beyond this body, all the stakeholders in the health sector must ensure that no difficulties interfere with the implementation of this important agreement. It is in fact a pledge of the Government's willingness to improve health coverage by giving the human resources the incentives to ensure that the minimum package of activities (PMA) is available as well as the complementary package of activities (PCA), and immunization in particular.

### **3.3.3 Preparation of medium-term policy and strategy papers to improve resource mobilization**

This reprogrammed document is based on the national policy and strategy papers. It is consistent with the guidelines and the objectives in the PNS and PNDS, and with those in the second-generation National Growth and Poverty Reduction Strategy Paper and the MDGs. The paper also takes into account the emergence of new national resources from the Petroleum Fund.

Chad adopted a new PNS at the January 1993 sectoral meeting. It was revised for the first time in March 1999 and a second time in September 2007 to adjust it to the different contexts. The current PNS covers the period from 2007 to 2015.

The new National Health Policy Paper was prepared in 2007 based on the Millennium Development Goals (MDGs) as well as the second-generation National Growth and Poverty Reduction Strategy (SCARP). The vision of the development of health for 2015 responds in particular to the necessity to meet the challenge of *“controlling the factors responsible for the high morbidity and mortality rates that affect children and women in particular, including diseases, exclusion and ignorance, in a context of good governance and dynamic development of the health system.”*

The general objective of the new National Health Policy is “to provide the population with access to quality basic services to accelerate the reduction in mortality and morbidity in order to contribute to achieving the MDGs by 2015.” It is based on six strategic guidelines, one of which is *“improving the provision of quality care for women and children.”* In this respect, the context of the policy addresses the global challenges financed by new innovative arrangements for health funding.

Finally, we note that the mobilization of funds for the National Health Policy and the PNDS is based on the activities that are identified in the annual operating plans prepared by the community stakeholders in the Regional Health Delegations and Health Districts.

### **3.3.4 Extension of geographical coverage**

It can be said that the construction and rehabilitation of health centres and hospitals are the result of implementing innovative policies and strategies as well as reforms undertaken by the MSP in human resources and the partnership.

The partnership (PPP) made possible a considerable extension of the accessibility to and

availability of health services. The provision of faith-based care amounts to about 20% of national health coverage, with 10% being provided by the Catholic network facilities: 80 health centres and 3 district hospitals. For Protestants, the Entente des Eglises et Missions Evangéliques au Tchad (EEMET) is the largest provider, with a network of 84 health centres and 1 hospital.

Contracting with partners thus increased health coverage significantly. The contract model in Chad applies to the entire non-profit sector: National and international NGOs (whether faith-based or not), bilateral cooperation and multilateral cooperation agencies. Contracting also made it possible to incorporate the private non-profit sector and the NGOs (COOPI, MSF, GTZ, SECADEV, BELACD) into the health map (6 of the 82 district hospitals are private with a public component). The MSP is developing an active partnership with its partners such as the WHO and UNICEF to strengthen SSD capacities. The SAASDE, introduced in Chad in 2002 in 3 districts, has improved the level of infant health indicators. An extension of this strategy in 18 Districts is in progress and will address the barriers related to access to and the availability of the services concerned, as well as their use. That is why the MSP adopted this strategy to implement the 2007-2015 national health policy. However, the SAASDE should be updated and strengthened by adopting the “Reach Every District/RED” strategy, which is the approach now recommended internationally to treat childhood diseases. This upgrade will require major efforts in resource mobilization to achieve the MDGs.

Moreover, since 2009, major efforts have been made by the MSP to strengthen the production of skilled employees and to manage their agents with support from the sector partners such as the AFD, WHO, European Union and the AfDB. Each year, the civil service hires 400 health care workers and they are assigned to the MSP. The MSP revised its strategy plan to develop human resources for 2000-2030 (PSDRHS) and prepared a 2010-2020 strategy plan. A career plan was prepared, as well as an epidemiological profile of human resources. The process of setting up a human resources observatory for health is under way, as well as the computerization of health employee management. A capacity building project for specialist physicians and medical-technical equipment in the regional hospitals has been prepared and validated. Resources are now being mobilized through the Government.



### **3.4: Obstacles that are not being dealt with in a satisfactory manner and that require additional GAVI HSS support**

Despite the steps taken by the Ministry of Health and its partners to ensure quality care, Chad's health system has encountered difficulties in increasing and maintaining immunization coverage. The main constraints include:

**3.4.1 Central level:** (i) poor planning, coordination and monitoring of interventions; (ii) a poor health information system; (iii) insufficient human resources, particularly in management; (iv) poor supply and distribution system for drugs and medical consumables; and (v) insufficient capacities to support the organization and management of the health care services.

#### **Poor planning, coordination and monitoring of interventions:**

The central level finds it difficult to provide effective support for planning and monitoring to the different levels. The implementation of the current PNDS has shown that operational planning and monitoring of the implementation of interventions have been poorly carried out, especially at the peripheral level due to a lack of realistic plans. Monitoring meetings are organized at different levels, but preparation is poor and the meetings are ineffective.

The coordination and monitoring of partner interventions by the central level is ineffective.

This situation limits the efficacy and synergy of the interventions, especially in immunization.

The poor health information system at the central level is one of the difficulties that could limit the capacities of the health system to support the interventions in favour of target groups, specifically immunization activities.

#### **A poor health information system**

The Health Information System Division (HISD), whose role is to publish a statistics yearbook on the health situation in the country, has difficulties collecting and analysing data due to a shortage of computer hardware and tools. This situation has delayed the publication of statistics yearbooks and has prevented decisions from being taken at the right time.

An assessment of the country's health information was performed and validated in December 2011 (Annex 9). The analysis of the report of this assessment revealed the steps to be taken to strengthen the Health Information System Division (HISD). The current reprogramming took this into account by planning to build HIS employee capacities in general and of the 10 Districts selected in particular.

#### **Insufficient human resources**

Deficiencies in personnel management are an obstacle to the availability and quality of services. Weaknesses are noted in the monitoring of health care staff documentation, a lack of recognition of efforts made by the staff and a lack of staff management directives.

This situation has caused a decrease in staff motivation and they are discouraged.

The major efforts that are now under way, made by the MSP with support from the WHO, the AfDB, and the AFD, should be strengthened by building the capacities of the Districts as well as the health facilities. The current reprogramming stresses the aspects related to the availability of skilled staff, in sufficient numbers, in the health facilities of the 10 Health Districts, as well as incentives for them.

#### **Poor supply and distribution system for drugs and medical consumables**

The poor supply and distribution system is characterised by the poor financial capacity of the drug procurement clearinghouse to provide a steady supply of drugs, consumables and small medical and technical equipment. This brings about frequent stockouts of drugs and medical consumables in health facilities. There is also a weakness in the PRA management framework and supervision and inspection missions are insufficient.

Through the social policy of the Head of State, materialized by establishing free emergency care, the Government has improved the availability of drugs in the hospitals. An assessment of free care carried out in November 2011 (Annex 10) recommended extending free emergency care to the health centres. The first funding tranche under the GAVI HSS proposal was for 100 health centres. To facilitate the implementation of these initiatives and to make them sustainable, support for streamlining drug management is necessary and urgent. One of the reprogramming interventions is to support the streamlining of drug management.

#### **Inadequate capacities to support the organization and management of health care services**

In most cases, the departments and units that face the problems mentioned above have a sufficient number of trained staff, yet they have problems providing technical support to the DSRs and the Districts to strengthen the health system to support immunization activities. Insufficient Directives (supervision sheets, monitoring and supervision procedures and mechanisms, the lack of an effective system for managing resources and information, logistics (computer hardware, means to supervise and supply drugs and other resources), and weak technical capacities are the main causes of this situation. This is why actions have been considered to strengthen the capacities of these departments so that they are able to coordinate the implementation of the proposal and control the use of resources.

This applies to the following: (i) Planning Department, (ii) Human Resources Department, (iii) Department for Pharmacy, Laboratories and Drugs, (iv) Health Care Services Organization Department, (v) General Department for Regional Health Care Action, (vi) Secretariat General, and (vii) the Office of the Inspector General.

#### **3.4.2 Intermediate level:**

Insufficient skilled human resources are limiting capacities at the regional level to support the Health Districts in implementing the interventions, especially supplying drugs, training and supervision.

To address these constraints, the following capacities are to be strengthened:

- DSR and HD planning;
- the management, monitoring and supervision of the districts and health centres.

Moreover, difficulties in managing health care data due to inadequate computer hardware and poor capacities of staff in charge of the SIS make it difficult to analyse and use the data that is collected. The lack of logistical resources means that the DSRs and Health Districts are unable to organize active collection strategies for monthly activity reports from the health facilities.

### **3.4.3 District level**

73% of the Health Districts (60/82) and 69% of the Responsibility Zones (770/1,114) are operational. However, because of the vast size of the country and the distances to be covered to reach hospitals and health care centres, only a small portion of the population has access to health care services. In effect, only 30% of the population has actual access to health care centres (radius of 5 km). The national health care policy is planning to organize advanced and mobile strategies to cover the population in Zone B (population living more than 5 km from the site of the health care centre) and the population in zones not covered (Responsibility Zone without a health centre). The shortage of skilled human resources remains the main constraint in the health care system at the District level, which limits basic quality health care for the population.

Data that is collected is not analysed at District level, making speedy decision-making at local level impossible. Moreover, there is a problem with the quality of this data due to the limited competence of certain health care workers and inadequate monitoring and supervision.

Since 2002, the SAASDE has been implemented in 3 Health Districts and has provided satisfactory results (15% reduction in infant mortality). However, the conclusions of the final assessment of implementing this strategy have shown that the slowdown in immunization coverage resulted in decreased staff motivation, and frequent stockouts of essential drugs and vaccines have been observed towards the third year of implementing the SAASDE, as well as District management teams with flagging enthusiasm for monitoring health committees and irregular monitoring sessions.

Overall, the obstacles which are not being controlled and which need GAVI HSS support can be summarized as follows:

- frequent stockouts in essential drugs and medical products in health facilities (hospitals and health centres);
- weaknesses in coordination and monitoring interventions at various levels in the health care system, particularly at the Health District level;
- weakness of technical and organizational capacities in management structures in Districts, hospitals, health centres and at the community level;
- insufficient skilled personnel: in terms of availability, motivation and training;

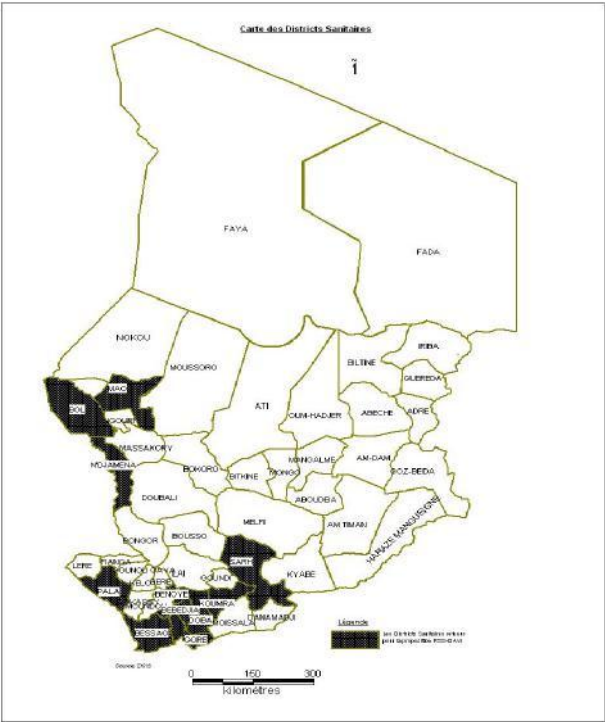
- inadequacies in terms of supervision, follow-up and monitoring in Districts, hospitals, health centres and at the community level;
- deficiencies in SNIS tools and mechanisms for collecting, compiling and using data at health care centres and at the community level.

Ten (10) all-terrain vehicles were purchased for the supervisions and given to the 10 Districts with funding from the first tranche of the GAVI HSS proposal. The reprogramming provides support to operate these vehicles as well as support for the supervisions and monitoring of the central level.

#### Part 4: Goals and Objectives of GAVI HSS Support

Map:

<b>Districts covered by the GAVI HSS proposal 10 Health Districts (DS) distributed over 8 regional Health Care Delegations (DSR)</b>		
<b>No.</b>	<b>DSR</b>	<b>DS</b>
1	<b>DSR of Western Longone</b>	<b>DS of Benoye</b>
2	<b>DSR of Eastern Logone</b>	<b>DS of Bebedja DS of Gore DS of Doba</b>
3	<b>DSR of Mandoul</b>	<b>DS of Koumra</b>
4	<b>DSR of Moyen Chari</b>	<b>DS of Sarh</b>
5	<b>DSR of West Mayo-Kebbi</b>	<b>DS of Pala</b>
6	<b>DSR of N'Djaména</b>	<b>DS of Ndjaména Centre</b>
7	<b>DSR of Lac</b>	<b>DS of Bol</b>
8	<b>DSR of Kanem</b>	<b>DS of Mao</b>



#### 4.1: Goals of GAVI HSS support

**Help reduce morbidity and mortality linked to vaccine-preventable diseases by strengthening the health system of 10 Health Districts by June 2014;**

#### 4.2: Objectives of GAVI HSS support

##### 4.2.1 General objective

Extend the SASDE to 10 Health Districts by June 2014 to increase and maintain immunization coverage as follows:

- 95% DTP3
- 95% TT2+ in pregnant women:

*(extend the SASDE as part of implementing the Reach Every District (RED) approach)*

##### 4.2.2 Specific objectives

- i. Strengthen the capacities of skilled and motivated health care personnel in the 10 chosen Health Districts by 2015;
- ii. Make the supply and management system of essential generic drugs and medical products efficient in the health facilities of the 10 Health Districts by 2015;
- iii. Strengthen the organization and management of services in the 10 Health Districts and 6 facilities at the central level by 2015.

#### 4.3 Main strategies and essential activities

The strategies used stem from the PNS (strategic focuses 1 and 2) and are divided into 3 areas of intervention: (i) human resources; (ii) rational management of essential drugs and medical products, including the cold chain and EPI vaccines/consumables; and (iii) organization and management of health care services, including at the community level.

These strategies and the main activities to be developed are summarised in the table below:

**Table 1: Description of the main strategies and related essential activities**

No.	Areas of intervention	Specific objectives	Main strategies	Essential activities
1	Strengthen human resources and capacities	Strengthen the capacities of the 10 Health Districts in terms of skilled and motivated health care personnel by June 2014	Strengthen the availability and technical capacities of staff members	<ol style="list-style-type: none"><li>1. Assign 100 more skilled staff to the 10 selected Health Districts.</li><li>2. Dispatch and settle 100 health care workers in the 10 Health Districts.</li><li>3. Collect and publish data on the effective presence of the 100 staff members in the 10 Districts.</li><li>4. Reward staff members with good performance based on merit.</li><li>5. Reproduce the EPI management tools and</li></ol>

				<p>the integrated formative supervision tools.</p> <ol style="list-style-type: none"> <li>6. Organize two MLM (mid-level management) training sessions for the District Management Teams (ECDs) in the 10 Health Districts.</li> <li>7. Train/retrain 118 health care workers from the different levels in EPI, FDD/IRA and PNC.</li> </ol>
2	Rational management of essential drugs and medical products	Make the supply and management system of essential generic drugs and medical products efficient in health care units in the 10 Health Districts by 2013.	<p>Improve managerial capacity in drugs and vaccines.</p> <hr/> <p>Strengthen the cold chain at the central level and in the 10 Districts for keeping vaccines</p>	<ol style="list-style-type: none"> <li>1. Train drug and vaccine management staff locally in the 8 regions and the 10 districts.</li> <li>2. Provide the 8 regions concerned (GAVI) with drug management and EPI tools.</li> <li>3. Carry out integrated formative supervision every three months in management tools, drugs, child survival activities, etc.</li> <li>4. Equip the central EPI with four 40 m3 cold chambers, and the three sub-national depots with three 40 m3 cold chambers (Moundou, Abéché and Sarh).</li> <li>5. Install the EPI equipment that is acquired (cold chambers).</li> <li>6. Provide each of the 8 DSRs and the 10 district departments with one freezer each.</li> <li>7. Provide the 8 DSRs and 10 district departments with one refrigerator each.</li> <li>8. Provide the 100 health centres with solar refrigerators.</li> <li>9. Distribute vaccines, consumables and EGDs to the 8 DSRS every 3 months.</li> <li>10. Provide drugs to the 100 health centres.</li> <li>11. Maintain the cold chain equipment.</li> </ol>

3	Organize and manage health care services, including at the community level	Strengthen the organization and management of services in the 10 health districts and 6 units at central level by June 2014	<p>Strengthen managerial and technical capacities in Planning/Coordination</p> <p>Strengthen service accessibility.</p> <p>Improve monitoring and integrated formative supervision.</p> <p>Strengthen EPI data management.</p>	<ol style="list-style-type: none"> <li>1. Support the organization of micro-planning workshops in the 10 Districts.</li> <li>2. Organize 2 PAO validation and adoption workshops in the 10 HDs.</li> <li>3. Support the monitoring meetings for actions in the 10 HDs.</li> <li>4. Support the annual PRDS review meetings for actions in 8 Health Delegations.</li> <li>5. Organize 3 reviews (twice a year) of the PNDS at the central level.</li> <li>6. Prepare, validate and adopt the new proposals to GAVI/Global Fund according to the platform.</li> <li>7. Provide the health centres selected in the 10 Districts with 100 motorcycles for the advanced strategies.</li> <li>8. Operate the 100 motorcycles.</li> <li>9. Operate the 10 vehicles purchased using GAVI funds and the two vehicles to be acquired.</li> <li>10. Support the organization of activities (EPI, PNC, Vitamin A, mebandozole, BCC, etc.) in fixed, advanced and mobile strategies, including market days.</li> <li>11. Provide the central EPI with a truck to distribute consumables, tools, cold chains, drugs and EPI consumables.</li> <li>12. Organize quarterly integrated supervision missions at the level of the HDs and DSRs concerned.</li> <li>13. Provide the central HSS coordination office and the EPI with two all-terrain supervision vehicles.</li> <li>14. Provide 6 central units, 8 DSRs and 10 DSs with computer and office equipment kits (desktop,</li> </ol>
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				<p>interruptible power supply, power strips, printers, adapters, photocopying machines, etc., to enter and process the data.</p> <p>15. Train the members of the 8 DSR teams and of the 10 Districts in GESIS data and software management.</p>
			<p>Improve links with the community</p>	<p>16. Train the health committees in the 10 HDs.</p> <p>17. Identify and train the community health care workers in the Responsibility Zones.</p> <p>18. Organize monthly meetings for monitoring the management committees and include the community health care workers.</p> <p>19. Put in place communication media such as posters, image boxes, etc., in the 10 HDs.</p>

#### **4.4 Details about the main activities**

This section highlights the fact that the reprogramming document focuses on the current needs of the EPI as shown in the external review of the EPI and the CmYP for 2013-2017. Although it does not abandon a systematic approach that aims to strengthen the current national system in a crosscutting and integrated manner, it provides first and foremost an adequate response to today’s immunization challenges in Chad.

The capacity of the reprogramming document to improve the performance of the principal stakeholders in fighting EPI vaccine-preventable diseases stems mainly from the fact that it effectively contributed to the implementation of the innovative strategies the MSP identified in this area: (i) the Reach Every District/RED approach, (ii) the integration of child survival activities into the minimum package of activities, and (iii) the acceleration of routine EPI.

##### **4.4.1 Strengthen human resource capacities**

###### **Strengthen staff availability and technical capacities**

The activities identified in this first area of intervention contribute to overcoming the first and most important obstacle that the overall management of the EPI faces: the shortage of skilled personal capable of offering quality services to the target groups. All areas of

immunization are affected: the provision of services, supply, logistics, and surveillance, or even advocacy. The 2013-2017 CmYP emphasizes the “human resources” obstacle and notes, for example, that the last time employees were trained in EPI management (MLM course) at the national level was in 2002. Therefore, it comes as no surprise that vaccine management is still insufficient, because it is dependent on insufficient and less skilled personnel at all levels. Therefore, the following steps should be taken:

- *Assign and dispatch 100 more skilled workers to the selected health districts.*

In previous years, the MSP received an annual authorization to hire 400 skilled employees. This quota was raised to 1,000 skilled employees in 2012. Of this figure, 100 employees will directly support the implementation of the EPI in the 10 HDs during the reprogramming period. They will be distributed in order to strengthen the management teams of these districts and to ensure the presence of 2 nurses per health centre, one of whom will be in charge of preventive activities including immunization, disinfestation, Vitamin A supplementation, PNC, etc., in accordance with the Strategic Human Resources Development Plan. They will be sent to the 10 HDs where their effective presence in the field will be regularly monitored. This effort will supplement the assignments made early in the implementation of the proposal.

- *Collect and publish data on the effective presence of the 100 employees in the 10 Districts*

This activity generated no costs. Publication will be in the EPI feedback newsletter and will be quarterly.

- *Reward 118 effective employees based on merit*

There are plans to reward 118 employees, broken down as follows: 100 employees in the health centres, 10 ECD employees, and 8 employees of the regional health delegations. Merit will be recognized during official ceremonies in the districts concerned and monetary incentives will be given. These are transitional arrangements that will evolve once PBS is universal.

- *Reproduce the EPI management tools.*

- *Organize two MLM training sessions for the DMTs in the 10 Districts concerned.*

- *Train and retrain 118 health care workers from the different levels in EPI, LMD/ARI and PNC.*

#### **4.3.1 Rational management of essential drugs and medical products, including EPI vaccines and consumables, as well as cold chain equipment**

##### Upgrade managerial capacity in the area of drugs and vaccines

- *Train drug and vaccine management staff locally in the 8 regions and the 10 districts.*

The employees concerned are the EPI manager and the pharmacy manager assigned to the peripheral (district) level and the intermediate level (regional health delegation). Training will thus be provided to 36 employees (16 for the 8 regions and 20 for the 10 districts).

- *Provide the 8 regions concerned (GAVI) with drug management and EPI tools.*

The training modules have already been prepared. The activity mainly entails reproducing them and then distributing them to all the employees concerned.

- *Carry out integrated formative supervision every three months in management tools, drugs, child survival activities, etc.*

The situational analysis presented in the 2013-2017 CmYP highlights a certain number of weaknesses in the provision of services, especially weaknesses due to the insufficient integration of the activities. We note, for example, that the integration of child survival activities (Vitamin A and mebendazole) are only carried out during the supplemental immunization activities (SIVs), or when long-lasting insecticide-treated mosquito nets (LLITNs). Initiatives that aim to improve this are therefore carried out under the reprogramming and should be supported using appropriate supervision methods that gradually contribute to making them sustainable.

### Strengthen the cold chain (CC) at the central and regional levels and in the 10 Districts for keeping vaccines

In the national CC assessment a plan to renovate the cold chain was prepared. It plans to equip the central EPI depot, three sub-national depots and the COSANs with cold chambers, freezers and solar refrigerators. The Government has begun the process of building and renovating the buildings that are to house this equipment.

- *Equip the central EPI with four 40m<sup>3</sup> cold chambers, and the 3 sub-national depots with three 40 m<sup>3</sup> cold chambers (Moundou, Abéché and Sarh).*

This requirement is justified by the fact that current central level storage capacity is limited to 8 m<sup>3</sup> certified. This situation is critical and makes it impossible to keep the vaccines under optimal conditions and to introduce new vaccines such as MenAfriVac, Pneumococcal and Rotavirus.

- *Provide each of the 8 DSRs with 2 freezers each and the 10 district departments with 1 freezer each.*
- *Provide the 8 DSRs and 10 district departments with one refrigerator each.*
- *Provide the 100 health centres with solar refrigerators.*

This CC equipment will strengthen storage capacities at the infra-national level: regions, districts and health centres. Most of these facilities have obsolete or unusable equipment so that vaccines cannot be kept under optimal conditions.

Upon the completion of the activities identified in this area of intervention, the rational management of vaccines, EGDs, consumables and cold chain equipment should improve considerably. This progress depends primarily on the attention paid to streamlining/optimizing the distribution process. Until now, this process is carried out haphazardly at the initiative of the peripheral managers who, according to the transportation opportunities available to them, take advantage of a trip to N'Djaména to bring back vaccines and drugs. This method creates serious adverse effects and is responsible for creating excess inventories as well as inventory shortages. The central EPI recently acquired a refrigerated truck, which helps upgrade the distribution system. It contributes to returning the supply circuit to normal so that the central level is able to assume its responsibility toward the lower levels, which involves the initial shipment to the DSRs. In turn, the DSRs should provide the same service to the districts on which they

depend. The above-mentioned cold chain equipment makes an essential contribution to this objective.

The vehicles acquired previously using GAVI financing are also part of this same concern for streamlining/optimizing distribution in the same manner. They contribute to the steady supply of EPI drugs, vaccines and consumables according to the current standard: from the regions to the districts and from the districts to the health centres in the districts GAVI supports.

#### **4.4.2 Strengthen Health District organization and management, including the community level**

This final area of intervention aims to strengthen the organization and operation of the Districts as well as the health information system to facilitate extending and monitoring the implementation of immunization activities in the 10 Health Districts. Therefore, we also propose strengthening capacities to coordinate partner interventions at the central as well as local level to facilitate their mobilization to support the PNS, the PNDS and the CmYP.

This is divided into 5 strategies that can be grouped into 3 themes:

- 1) Strengthen Planning/Coordination managerial and technical capacities, improve monitoring and formative supervision and strengthen the management of EPI data;
- 2) Improve access to the services;
- 3) Improve links with the community.

The first thematic group is related directly to the “*Global Strategy for Women’s and Children’s Health to Accelerate the Achievement of Millennium Development Goals 4 and 5 (MDGs)*.” In September 2010, the Secretary General of the United Nations launched the Global Strategy for Women’s and Children’s Health to Accelerate the Achievement of Millennium Development Goals 4 and 5 (MDGs).” For this purpose, an Information and Accountability Committee for Women’s and Children’s Health was set up. It laid down a certain number of key principles related to accountability, in particular the principle of building national capacities for monitoring and evaluation. In particular, it identified 7 priority areas for strengthening for which countries can obtain technical and financial assistance. One of these areas is Monitoring Outcomes (health information system and monitoring/evaluation) and the Review Process. The core of the *Global Strategy* is linked directly to the production and use of comprehensive health information that is also relevant, accurate and of good quality.

The strategies for intervention area 3 are thus aligned with the Global Strategy that should make it possible to achieve MDGs 4 and 5. Exercises of micro-planning, preparing regional health development plans, as well as the review process increase distribution, sharing and dialogue around immunization problems. They are an opportunity to raise the awareness of all stakeholders and to find the most appropriate solutions.

The second thematic group, “*improving access to services*” is a fundamental challenge in Chad. In nearly the entire country, the traditional fixed strategy is insufficient on its own to cover needs. Zones that are difficult to access have insufficient advanced and mobile strategies. Moreover, the existence of non-functioning Responsibility Zones heightens the necessity of finding sustainable and cost-effective responses in terms of advanced and mobile strategies.

Finally, the last thematic group, “*improving links with the community*,” requires an assessment of community participation, whose level and quality are still below the expectations of the MSP and Chad’s partners. A revitalized community approach is necessary. The activities proposed in the Reprogramming Document are the initial phases of a process that can be scaled up and carried out to the extent that the results of the formative supervisions to be carried out will provide clear indications on the outcomes. Appropriate monitoring and supervision must be an essential dimension of activities to strengthen interactions between the community and the health system.

## **Part 5: GAVI HSS activities and implementation schedule**

### **5.1 Sustainability of GAVI HSS support**

The goals, objectives and strategies of this proposal fit into a framework to develop the broader health system to contribute to the sustainability of the interventions to be developed.

The purpose of this proposal, which is to contribute to raising and maintaining immunization coverage, includes the objectives in the new National Health Policy (PNS) for the period up to 2015 (Annex 11) based on the Millennium Development Goals (MDG), the performance-based strategy (PBS) and the National Poverty Reduction Strategy (SNRP2).

This proposal is also consistent with the other strategies: the national immunization policy, the human resources development policy, and the national drug policy. It will without fail help achieve the Millennium Development Goals (MDGs) because it targets two vulnerable groups: children under 5 years old (MDG 4, target 5) and pregnant women (MDG 5, target 6). The various interventions planned in the National Health Development Plan comprise actions to strengthen the technical and management capacities of the stakeholders from the various levels of the health care system, including communities concerned by implementing and monitoring the PNS.

These types of interventions are also included in the GAVI health system strengthening proposal.

In this regard, there are plans to strengthen the organization and management structures of the District management teams, DSRs and the central level.

This strengthening will entail reorganizing these structures to make them more efficient by using directives, tools and procedures to manage resources and drugs in particular. Next, it is planned that these structures will be strengthened in terms of skilled human resources by assigning competent managers and training them in management. Short-term international assistance in various areas will help strengthen the technical capacities of managers at the central as well as regional level. For the district level, the regional level teams, supported by the central level teams, will be responsible for providing a supervisory framework to work closely with district and community management teams in terms of resource management and monitoring. Regarding the district teams, there will be training in management, developing operational plans, using tools and procedures to manage activities and resources and drugs, and organizing supervisions and monitoring essential interventions in mother and child health.

At the community level, the roles and responsibilities of health committees will be reorganized and training will be provided in developing micro-planning and organizing the follow-up of mother and child health interventions at the community level (monitoring).

## 5.2 Implementation schedule

The reprogramming of GAVI support for health system strengthening in Chad is scheduled to last 18 months from June 2012 to December 31, 2013. The detailed timeline for implementation is annexed to this document.

## Part 6: Monitoring, evaluation and operational research

### 6.1: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
<b>Impact and outcomes</b>			
1. National DTP3 coverage (%)	Health centre level	Health centres, Districts, DSR and DSIS	Health centres, including communities, districts, DRS and central
2. Number / % of districts achieving $\geq$ 80% DTP3 coverage	Health centres, Districts, DSR and DSIS	Health centres, Districts, and DSR	Central level, cabinet, MSP, central departments, DSIS, Researchers, DS, DSR
3. Mortality rate for children under 5 (per 1,000)	National population survey	INSEED, DSIS	Governments, MSP partners, central SMP departments, DRS, DS, researchers
4. Number of hospitals and health centres that have had at least 6 visits in the year ended during which a quantified checklist was used	CS, DS, DSR, DSIS	CS, DS, DSR, DSIS	CS, DS, DSR, COSAN, central departments, MSP partners
5. Number of health centres with skilled health care workers in the required numbers who are present in the Responsibility Zone at least 10 out of the 12 months of the last month	CS, DS, DSR, Human Resources DSIS	CS, DS, DSR, Human Resources Department, DSIS	Governments, MSP partners, central MSP departments, DSR, DS, CS
6. Average number of days of stockouts in ten types of essential drugs during the last quarter	CS, DS, DSR, Pharmacy department, laboratory and drugs, DSIS	CS, DS, DSR, Pharmacy department, laboratory and drugs, DSIS	CS, DS, DSR, Pharmacy department, laboratory and drugs, Government, MSP partners, SG/MSP, MSP partners [sic]
<b>Activity</b>			
1. Number of DSR and District teams selected whose capacities have been strengthened for collecting and managing health information	DSR, DS, DSIS	DSR, DS, DSIS	DSR, DS, DSIS, MSP cabinet, DGASR, SG/MSP, MSP partners
2. Number of hospitals and centres whose staff has been trained in	DSR, DS, DSIS	DSR, DS, DSIS,	DSR, DS, DSIS, Pharmacy department (DPLM), MSP cabinet, SG/MSP, MSP

drug management and control, including vaccines and medical products		Pharmacy department (DPLM)	partners
3. Number of health centres and hospitals, community members whose staff has been trained in IMCI, PNC and EPI	DSR, DS, CS, DSIS	DSR, DS, CS, DSIS	DSR, DS, CS, DSIS, DOSS – MSP cabinet, SG/MSP, MSP partners
4. Number of monitoring sessions organized per centre per year	DSR, DS, CS, DSIS community	DSR, DS, CS, DSIS, community	DSR, DS, CS, DSIS, community, MSP cabinet, SG/MSP, MSP partners
5. Number of advanced strategy sessions organized per health centre and per year	DSR, DS, CS, DSIS community	DSR, DS, CS, community, and DSIS	DSR, DS, CS, DSIS, community, MSP cabinet, SG/MSP, MSP partners
6. Number of supervision missions organized per District per year	DSR, DS, CS, DSIS	DSR, DS, CS, DSIS	DSR, DS, CS, DSIS, MSP cabinet, SG/MSP, MSP partners

## 6.2 : Strengthening the M&E system

The collection of data to monitor the results indicators and effects of implementing the principal interventions of the proposal will be based on existing mechanisms (routine SIS data, supervisions of the different health system levels, and monitoring at the community level). For this purpose, the health facilities, Health Districts and the DSRs will be strengthened for the collection, prompt transmission, analysis and use of routine data to have fast and reliable information for effective decision-making. Moreover, strengthening existing mechanisms for monitoring some of these indicators is necessary. This is particularly true for the *average number of stockout days for 10 essential drugs in the health centres during the last quarter, supervision of health centres and the number of months the workers are at their station.*

Moreover, there are plans to strengthen DSIS capacities to incorporate these indicators into the upcoming health statistics analysis. To this end, the capacities of the DSRs, DSs and health facilities will also be strengthened for data collection and analysis. At the community level, the twice-yearly monitoring sessions will be strengthened to incorporate the collection and analysis of the indicators.

Strengthening these existing mechanisms for data collection, analysis and use will also improve the quality of the data necessary to assess the other indicators linked directly to immunization coverage for children under five. (National DTP3 coverage (%), number of percentage of districts achieving  $\geq 80\%$  DTP3 coverage).

## 6.3: Operations research

The reprogramming selected analyses to address certain constraints the health system is facing which limit decision-making so that a satisfactory response can be organized. To this end, there are plans to:

- strengthen the monitoring of activities implemented at the community level and improve the population's involvement in monitoring activities for immunization and other operations for children and women. A study is to be carried out in 2012 to obtain baseline data to monitor the indicators.



## Part 7: Arrangements for implementing the proposal

### 7.1: Management of GAVI HSS support

Management Mechanism	Description
Name of lead individual / group responsible for managing the implementation of GAVI HSS reprogramming	<p>Mr. Moussa Issaye, Director of Planning and Chair of the Technical Committee, is the lead individual for managing the implementation and M&amp;E of the proposal.</p> <p>Funds management will focus on four aspects: (i) programming for activities, (ii) financial management, (iii) procurement, and (iv) monitoring/ evaluation</p> <ol style="list-style-type: none"> <li><b>Programming of activities:</b> The reprogramming will be broken down into quarterly work plans highlighting activities to contribute to achieving annual objectives and therefore the overall targets. Activities will be planned for 18 months with clearly identified responsibilities. There are the human, material and financial resources for these activities in accordance with the main MSP planning document.</li> <li><b>Financial management:</b> Financial resources made available to the MSP will be managed according to MSP procedures. This management is to be audited by the Office of the MSP Inspector General’s staff and by State inspection if required. Audits could be planned if necessary.</li> <li><b>Procurement:</b> This is based on procedures for public contracts that ensure transparency and that obtain the best products at the best prices. An acquisition plan will facilitate the execution of purchases so that products can be available on time.</li> <li><b>Monitoring &amp; evaluation.</b> The MSP uses several monitoring and evaluation tools through the Health Information System Division, that is, site visits, periodic reports, consultation meetings, and external evaluations. All activities are subject to the monitoring/evaluation system each year.</li> </ol>
Role of the IACC	<p>The Inter-agency Coordinating Committee is the decision-making body to implement and monitor GAVI HSS support. It will be responsible for approving the proposal and its budget, approving action plans and the quarterly budgets to implement the reprogramming as well as certain large purchases. The IACC organizes the quarterly monitoring meetings and various reviews.</p>
Mechanism for coordinating GAVI HSS with the other system activities and programmes	<p>Coordinating GAVI HSS support will be integrated into the coordination interventions with the partners. Statutory coordination and consultation meetings between the MSP and partners at various levels in the health care system will be held to evaluate and coordinate the GAVI support.</p> <p>Site visit reports, annual reports and evaluation reports will be used for consultations with coordinating bodies, partners and stakeholders and the populations receiving the grants.</p>

## 7.2 Roles and responsibilities of key partners (HSCC members and others)

<b>Title/Position</b>	<b>Organization</b>	<b>HSCC member yes/no</b>	<b>Roles and responsibilities of this partner in implementing GAVI HSS</b>
UNDP representative in Chad	UNDP office in N'Djaména	Yes	Coordinate the interventions of the United Nations system to help monitor GAVI HSS support
WHO representative in Chad	WHO office in N'Djaména	Yes	MSP advisor, leader of Ministry of Health partners. The WHO representative facilitates mobilizing MSP partners in analysing and adopting the GAVI HSS proposal as well as monitoring the implementation of this proposal. The WHO is also the preferred partner for mobilizing technical assistance, particularly for studies.
UNICEF representative in Chad	UNICEF office in N'Djaména	Yes	Key MSP partner in implementing the SAASDE and supplying vaccines. Plays an important role in adopting the proposal and supporting implementation.
World Bank representative in Chad	World Bank office in N'Djaména	Yes	Important partner for supporting HSS in the development of human resources and will facilitate the adoption of the GAVI HSS proposal as well as monitor the implementation of this proposal.
French Cooperation representative in Chad and adviser from the Ministry of Public Health	AFD office in N'Djaména	Yes	Important partner for supporting HSS in the context of adopting the GAVI HSS proposal and monitoring the implementation of this proposal.
EEMET representative	EEMET office in N'Djaména	Yes	Important partner of the Ministry of Public Health (MSP), participates in improving health care coverage with important health care units. He will facilitate GAVI HSS implementation in addition to other faith-based NGOs.
Islamic Committee representative	Office in N'Djaména	Yes	Important partner of the Ministry of Public Health (MSP), participates in improve health care coverage with important health care units. He will facilitate GAVI HSS implementation in addition to other faith-based NGOs.
CILONG representative	Office in N'Djaména	Yes	Will facilitate the mobilization of NGOs in improving interventions in health regarding the adoption, implementation and monitoring of GAVI HSS.
CELIAF representative	Office in N'Djaména	Yes	Will facilitate the mobilization of associations involved in improving interventions in health regarding the adoption, implementation and monitoring of GAVI HSS.

### 7.3 Financial management of GAVI HSS support

Mechanism/procedure	Description
Mechanism for transferring GAVI HSS funds to the country	A bank account is opened under the name of the GAVI HSS steering committee. Based on the action plan and the budget, funds will be sent to this account.
Mechanism for transferring GAVI HSS funds from central level to the periphery	Each chief district physician (MCD) has a bank account in the principal town of its DSR. The Committee Chair will transfer funds based on District plans and budgets validated by the technical committee and approved by the IACC. For DSRs that do not have banking institutions, accounts will be opened in the closest locality for these Districts or in N'Djaména.
Mechanism (and responsibilities) for budget use and approval	<p>At the central level, two signatures are required to release funds from the main account managed by the Director for Planning, Secretary General of the Ministry of Public Health, Chair of the Steering Committee (or his assistant), and the WHO Representative (or his administrator).</p> <p>At the DSR and District level, at least two (2) signatures including the various stakeholders affected by GAVI HSS implementation and monitoring are required to release funds from each DSR or DS account. A signature from the DSR or MCD seconded by another signature of one of the partners' representatives.</p> <p>Each DSR, each MCD and each Technical Director is responsible for using the funds made available to him based on the budget line items approved by the steering committee. He will report on his management to his supervisors and to populations organized into the health committees. Quarterly financial reports will be sent to the IACC via the Planning Director. At the central level, the technical committee will report periodically on its management to the IACC.</p>
Mechanism for disbursement of GAVI HSS funds	GAVI HSS will transfer funds to the management committee account based on action plans approved by the IACC and budgets supporting these plans as well as financial reports from previous transfers. A periodic request based on management mechanisms adopted by the IACC will be sent to GAVI HSS.
Auditing procedures	<p>Audit missions will be organized every 3 or 6 months or as required and at the discretion of the Office of the Inspector General of the MSP. Other audits at the Government level will be commissioned if required through State audit missions. External audits could be planned if required.</p> <p>Reports from all these audit missions will be made available to the steering committee to facilitate decision-making to streamline the management of the resources made available to the various recipients of GAVI funds.</p>

## 7.4 Procurement procedures

Existing procedures will be used for procurement. Two procurement types are planned: procurement of equipment and procurement of drugs and medical consumables.

Equipment (vehicles, cold chain and other equipment) will be purchased according to Ministry of Public Health Procedures.

Drugs and medical consumables will be purchased through the Drug Procurement Clearinghouse (PCA). The PCA, created by law 33/PR/94, is responsible for purchasing and distributing drugs, technical materials and consumables for the health care sector. The PCA has the status of an autonomous public establishment (Law No. 33/PR/95 of 22<sup>nd</sup> October 1994 and Decree No. 10/PR/MSP/95). This structure has been operational since December 1996. It ensures the proper coordination and better management of essential drugs in the public sector and the non-profit private sector.

## 7.5 Reporting arrangements

An efficient mechanism based on existing measures is needed to plan the interventions, implement and monitor the progress achieved and the use of resources mobilized in the context of GAVI HSS.

First, this mechanism will ensure the relevance and consistency of the chosen interventions in the action plans. It must also help mobilize and allocate these resources for implementation, and it must in particular facilitate the judicious use of these resources and facilitate the progress to be achieved once the interventions have developed.

This mechanism comprises measures to monitor the implementation and use of funds at various levels in the health care system. These measures strengthen the existing mechanism and involve stakeholders affected by the health care system with a view to transparency and complementarity of interventions. In this regard, external partners of the Ministry for Health, civil society and NGOs are represented here.

These measures comprise: (i) a management committee; (ii) an Inter-agency Coordinating Committee, the Management Committee (central level), the annual steering committee (consisting of the DSRs and the central level), and the Management Committee at the District level.

The Management Committee (CG) is an entity set up at the various levels in the health care system by the Ministry for Public Health to manage GAVI HSS interventions and resources.

At the District level, the Management Committee will be chaired by the Chief District Physician, who will be seconded by a representative of a MSP partner. Other stakeholders in the Districts will be members of the management committee.

At the central level, the CG will be chaired by the Director for Planning, who will be seconded by the WHO representative. Members of the management committee will be: Director General of Regional Health Care Action (DGASR), director of the health care services organization (DOSS), human resources director (DRH), director of pharmacy, laboratories and drugs (DPLM), director of reproductive health and immunization (DSRV),

head of cooperation and research bureau (BCE), coordinator of the Expanded Programme on Immunization. The management committee will be supported by monitoring and evaluation experts. These experts will be provided by the MSP's partners if required and will not be permanent.

### 7.6: Requirements for technical assistance

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Carry out a rapid survey to obtain baseline data available on certain indicators linked to human resources, and in particular to the availability of employees in their unit, supervisions, and drug stockouts.	30 days	4 <sup>th</sup> quarter of 2012	Local