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**Application Form:**

**Health System Strengthening (HSS) Support**

**in 2016**

**Deadlines for submission of application:**

*15 January 2016*

*1 May 2016*

*9 September 2016*

Document dated: October 2015

(This document replaces all previous versions)

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| **Application documents for 2016:**  Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below: | |
| **HSS Application Form** | **Purpose of this document:**  This application form must be completed in order to apply for Gavi’s HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.  The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian. |
| **Weblinks and contact information:**  All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact [applications@gavi.org](mailto:proposals@gavi.org) or your Gavi Senior Country Manager (SCM). | |

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# Part A: Summary of support requested and applicant information

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| 1. Applicant information | | |
| **Total funding requested from Gavi (US $)** | *This should correspond exactly to the budget requested in Question 17 (detailed budget).* | |
| **Does your country have a finalised and approved National Health Sector Plan?** | Yes  X | No |
| *Indicate the* ***end year*** *of the NHSP:* ***2025***  ***Provide Mandatory Attachment #8: NHSP*** | |
| **Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?** | Yes  X | No |
| *Indicate the end year of the cMYP:* ***2020***  *Provide* ***Mandatory Attachment #11****: cMYP* | |
| **Proposed HSS grant start date:** | *Indicate the month and year of the planned start date of the grant*.  **July, 2016** | |
| **Proposed HSS grant end date:** | *Indicate the month and year of the planned end date of the grant.*  **December, 2017** | |
| **Joint appraisal planning:** | *Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.*  **Q2, 2016** | |

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| 2. Application development process *(Maximum 2 pages)* |
| *Provide an overview of the collaborative and participatory application development process.*  *Include the following* ***Mandatory Attachments:***  ***#4****: Minutes of HSCC meeting, at which the HSS application was endorsed;*  ***#5****: Last 3 minutes of HSCC meetings; and*  ***#15****: TOR of HSCC*  *Preparation of the Health System Strengthening (HSS) proposal for Angola for submission to GAVI comprised the following steps.*   * *Retaining a consultant to work together with the National Public Health Department and the Statistics Division of the Research, Projects and Statistics Office of the Ministry of Health (GEPE) and technical representatives of WHO, UNICEF and the CORE Group.* * *Documentary review of plans, programs, projects, reports and assessments followed by consultations with MINSA and cooperation agency technicians.* * *In order to identify problems and prioritise the same, four discussion groups were organised with EPI technicians from the 18 provinces, including technicians from municipalities of Luanda and WHO focal points in the provinces, who met in Luanda, to participate in an assessment meeting. Each of the groups organised comprised provinces with similar performance and difficulty characteristics. In this manner, meetings were in separate sessions of nearly one hour for each group. In these sessions, their perceptions were collected with respect to the bottlenecks and EPI issues, and those factors that do not allow high coverage, particularly in rural and peripheral urban areas, and this input was used to describe the problems and to prioritise project actions.* * *The first draft was reviewed in detail by technicians and the National Health Directorate. The document was subsequently widely distributed over the Internet, by the Immunisation Section Chief with the implementation partners—WHO, UNICEF, USAID, World Bank, including members of the Pediatric Society CORE Group, the GEPE Statistics Department, the Municipal Development Project of the Health System, the Red Cross, Rotary International and others. Suggestions were received and were incorporated into the document.* * *The focal point for Health System Strengthening from WHO participated in the entire process of preparation, validation and finalisation of the proposal, as well as technicians from the EPI, MINSA and WHO. UNICEF technicians provided technical contributions and guided the cold chain procurement component and means of transportation.* * *A meeting was organised for the technical validation of the document, led by the National Directorate of Public Health, with participation by technicians from several departments of the Ministry of Health, partners and project supervisors. During this meeting, the document was presented and criteria for the selection of provinces and determination of priority actions were shared. Modifications were then made.* * *Lastly, the draft of the Project was presented to the Interagency Coordinating Committee which was coordinated by the Minister of Health. The heads of Agencies from WHO, UNICEF, USAID, program and health project directors and members of civil society organisations participated in this meeting. During this session, the project was approved and the need to mobilise even more resources in order to confront the challenges to Health System Strengthening was discussed. The submission of the document to Gavi was authorised.* |

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| 3. Signatures | | | | |
| **3a. Government endorsement** | | | | |
| *Include Minister of Health and Minister of Finance endorsement of the HSS proposal –* ***Mandatory Attachment #2.***  **We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.**  **Minister of Health** (or delegated authority) **Minister of Finance** (or delegated authority)  Name: Dr. José Vieira Dias Van-Dúnem Name: Dr. Armando Manuel  Signature: Signature:  Date: Date: | | | | |
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| **3b. Health Sector Coordinating Committee (HSCC) endorsement** | | | | |
| *Include HSCC official endorsement of the HSS proposal –* ***Mandatory Attachment #3***  *Include a signature of each committee member in attendance and date.* | | | | |
| **Mandatory Attachment #3: HSCC Endorsement of HSS Proposal**  *We the members of the HSCC, or equivalent committee met on the January 08 2016 (date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.* | | | | |
| **Please list all HSCC members** | **Title / Organisation** | **Name** | **Sign below to confirm:** | |
| **Attendance at the meeting where the proposal was endorsed** | **Endorsement of the minutes where the proposal was discussed** |
| **Chair** | Minister of Health/MoH | Dr. José Vieira Dias Van-Dúnem |  |  |
| **Secretary** | EPI Team Leader/WHO | Dr. Jean Marie Kipela |  |  |
| **MOH members** | National Director of Public Health/MoH | Dr. Adelaide de Carvalho |  |  |
| **MOH members** | Cabinet of Planning and Projects (GEPE)/MoH | Dr. Daniel Antonio |  |  |
| **MOH members** | EPI manager/MoH | Dr. Alda Morais |  |  |
| **MOH members** | Reproductive Health/MoH | Dr. Henda Vasconcelos |  |  |
| **MOH members** | Department of Epidemiology/MoH | Dr. Eusebio Manuel |  |  |
| **Development partners** | Paediatric Society/MoH | Dr. Margarida Correia |  |  |
| **CSO members** | CORE Group/MoH | Ms. Ana Pinto |  |  |
| **CSO members** | Rotary International/MoH | Mr. Manuel de Sousa |  |  |
| **CSO members** | Red Cross | Dr. Walter Quifica |  |  |
| **WHO** | Representative WHO | Dr. Hernando Agudelo |  |  |
| **UNICEF** | Representative UNICEF | Dr. Francisco Songane |  |  |
| **USAID** | Director of Mission | Mr. Jason Fraser |  |  |

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| 4. Executive Summary *(Maximum 2 pages)* |
| *Provide an executive summary of the application.*  *Angola is a democratic republic located on the Atlantic coast of Sub-Saharan Africa and in some of the largest countries on the continent; 1.2 million km2. The country is divided politically and administratively into 18 provinces, 161 municipalities and 618 villages. Angola is multicultural and multilingual, and the official language is Portuguese. The national population census conducted in 2014 showed that the population of the country was 24.4 million inhabitants, of whom 62% were concentrated in urban areas. In the capital of Luanda, 43 of the % of national urban population was concentrated, and 27% of the total population of the country. The Angolan economy is primarily based on petroleum income; in 2013, petroleum revenue was estimated at 80% of the GDP. Throughout 2014 and 2015, the Angolan economy softened due to the dramatic drop in international petroleum prices.*  *During the past decade the Government of Angola has made significant efforts to create conditions that will facilitate the strengthening of the National Health System, a situation which has been supplemented by the rapid economic growth of the country and significant political will. Pease has provided for the reconstruction of the infrastructure of the public health network after more than 3 decades of war, which represented one of the primary advances made by the Country. In this regard, investments were made related to rehabilitation, construction, equipment for health care structures, creation of new jobs for health care personnel, as well as the training of human resources for health care facilities. Notwithstanding the progress made, the public network is sparse and is unequally distributed, favouring urban areas and the coastal provinces and the centre of the country, which are the most populated areas. It is estimated that approximately 20-30% of the population does not have geographic access to basic health services.*  *This Health System Strengthening Project (HSS-Gavi) is intended to deal with those factors that restrict enhancement of coverage, equity and quality of immunisation. At the same time, it is intended to strengthen the critical components of the Health System that contribute to the long-term sustainability of immunisation activities, by integrating them with other interventions comprising the essential package of mother and infant care and services.*  *The HSS-Gavi is part of the 2012-2025 National Health Development Plan of MINSA, the 2016-2020 EPI Multiyear Plan, the 2015-2017 Gavi-Government of Angola Graduation Plan and the results of the situational analysis and the lessons learned to implement prior projects and plans. Its purpose is to contribute to national efforts to increase routine immunisation coverage for all antigens to reach 87% or more of the target population of the Country in 2017, while reducing the primarily geographic inequalities of access and improving immunisation quality.*  *The HSS-Gavi project is budgeted at 3.97 million US Dollars, and will last 18 months, from July 2016 through December 2017. It will benefit 11 provinces and 97 municipalities with the worst indicators, in the aggregate accounting for 62% of the national population (25,066,028 in 2015) and 67% of the absolute number of non-immunised children in the country in 2015 (390,610). The provinces were selected based upon criteria of low immunisation coverage, a higher proportion of municipalities with Penta 3 coverage below 80%, greater dispersion of population, a lower number of health units per inhabitant and an absolute number of non-immunised children per province that shows potential for improving national coverage. Thus, the provinces selected were Cunene, Namibe, Malange, Zaire, Huila Cuanza Sul, Cuanza Norte, Cuando Cubango, Bié, Lunda Norte and Luanda (only the higher populated municipalities of Viana, Cacuaco and Belas), which have rapid demographic growth and weak health infrastructure). In the selected provinces, the project focuses on 30 difficult-to-access municipalities.*  *The HSS-Gavi is broken down into five components, specifically: (1) Expansion of the provision of quality immunisation services in the public health system (29% of Project funds); (2) Expansion of the cold chain storage capacity, improvement of vaccine logistics and maintenance of cold chain equipment (47% of project funds); (3) Improvement of interpersonal educational communication related to health (7% of project funds); (4) Improvement in data quality and usage, monitoring, assessment (10% of Project funds); (5) National capacity building for management and determination of sustainable evidence-based immunisation policies (2% of Project funds). Five percent of the funds were reserved to cover administrative costs of the project (WHO/UNICEF). The majority of the funds will be disbursed in the first year (74%) due to the cost of the major volume of cold chain equipment and also because vehicles will be purchase d in 2016.*  *The development of human resources at the operational level of health care facilities that is in the last instance the level responsible for providing quality services has as its basis the standard WHO training package "Immunisation in Practice", and the formative supervision activities that will be strengthened by the purchase of 11 vehicles, per diems and 30 smart phones for sending data in real time at the provincial and national levels. Thirty motor vehicles will also be purchase d for difficult-to-access municipalities. The training of provincial and municipal supervisors in the Mid-level Management (MLM) program of the EPI is not part of this project, since it is part of the Gavi Graduation Plan.*  *A priority area of the project is to enhance the cold chain and vaccine management, which currently have many gaps. In this regard, although the HSS-Gavi will contribute to expansion of the cold chain for public health services by the procurement of 180 solar-powered cooler chests, primarily for rural and peripheral urban areas, and the augmentation of their storage capacity at redistribution levels through the purchase and installation of a cold room in Juila and the provision of 38 solar-powered cooler chests for municipal levels that have a deficit. The sustainability of the EPI also has to do with technological aspects covered by this project, such as the gradual conversion from gas-powered cold chain equipment to standardised solar equipment (SDD) approved by WHO/Unicef, which are more sustainable, easy to maintain, have a long service life and have greater storage capacity, which facilitates their use particularly in remote rural areas and urban areas that experience frequent electrical power disruptions. The use of continuous temperature control equipment (included in the graduation plan) will improve quality control for the preservation of vaccines. The purchase of spare parts for the cooler chests and motorcycles purchase d, so as to extend their service life, will also be considered. The project will improve the capacities of the 11 provincial and 97 municipal logistics centres in effective vaccine management, installation, preventive maintenance and the repair of cold chain. The remaining 7 provinces of the country will be supported with funds from the Graduation Plan.*  *The mothers’ health and children’s guardians educational empowerment component supplements the activities to be performed with resources from the Graduation Plan, and are focused on improving knowledge and skills of nursing personnel to carry out interpersonal educational communication on immunisation during each contact by users with the health services. The HSS-Gavi intends to reactivate local NGOs and also contribute to implementing the National Community and Health Development Agents (ADECOS) program, through local trainings to mobilise communities for the promotion of their own health. Promotion of participation by traditional authorities and other community leaders will contribute to increasing and qualifying the demand for immunisation and will assist in catching up those children who do not follow through with immunisation.*  *The administrative data for routine immunisation, even though they are the most structured data in the health system, have problems, primarily with regard to opportunity, integrity and the reliability of the same. Estimating routine immunisation coverage has been made more difficult as well with the lack of reliable population data, because the recent national survey of the population was conducted in May 2014, 44 years after the 1970 census. The definitive results of the census are not yet available. For the improvement in data quality, monitoring of performance indicators and the use of information to improve program management and the provision of health services, this project is focused on the institutionalisation of quality control and usage processes for data at all levels, the performance of meetings every two months to analyse information and decision-making in municipalities with the participation of supervisors from health facilities and members of communities and semi-annual evaluation meetings in the provinces with technicians from the municipalities and monthly meetings of the technical, logistical, social mobilisation and financial subcommittees at the provincial and central level.*  *The project does not include training to improve data management or data quality self-assessment (DQS), or the purchase of computer equipment, because it will be purchase d with Graduation Plan funds and will be used for the activities planned in the HSS-Gavi.*  *The HSS-Gavi provides for technical support for MINSA to help prepare a Supreme Decree proposal governing the use, monitoring and control of financial resources that were decentralised directly for the municipal administrations to ensure operational primary health care activities. These funds correspond to 60% of the Ministry of Health budget and helps to reduce geographic inequities of access to health services through mobile and advanced teams that provide immunisation services in communities without health care services, as well as transportation logistics, cold chain maintenance and support for health unit supervision.*  *The HSS-Gavi will complement the Gavi Graduation Plan by means of support for establishing and institutionalizing regular NITAG meetings so that this independent entity may become involved in the process of promoting and defining sustainable immunisation strategies and policies. A NITAG representative will be invited to participate in regular meetings of the Interagency Coordinating Committee (ICC).*  *During ICC meetings, coordination will be improved with the Municipal Health System Revitalisation Project funded by the World Bank, the European Union Project for establishing integrated health information platform and the Global Fund Health System Strengthening Project, actions will will allow MINSA to better manage external cooperation.*  *The HSS-Gavi also attempts to improve the central management capacity of MINSA to complement the support already committed to the Gavi Graduation Plan by means of contracting 2 national consultants for 17 months for (a) capacity building of Procurement Centre for Medication and Equipment (CECOMA) personnel in efficient purchasing processes and (b) management and maintenance of the immunisation cold chain and logistics for the national EPI. It is likely that this consultant will replace the national MINSA logistics supervisor who is in the process of retiring.*  *A health economist should also be contracted for 4 months to support the National Public Health Department and the Secretary General of MINSA in developing sustainable immunisation financing strategies as well as mechanisms for monitoring use of the budget and payment of Gavi co-financing.*  *For implementation of the HSS-Gavi, general coordination of the use of resources and integration with funds from the Government and other external sources will be carried out by the Interagency Coordinating Committee (ICC), chaired by the Minister of Health, including representatives from the WHO, UNICEF, USAID, CORE Group, the Red Cross of Angola, Rotary International, the Society of Pediatrics and the Project for Strengthening Municipal Health Services from World Bank. The ICC considers and approves presented by the technical group, monitors implementation of activities and facilitates facilitates the integration of resources and problem solving. ICC meetings are held every two weeks/monthly.*  *At the central level, the primary implementation entities of the HSS-Gavi will be: The National Public Health Directorate of the Ministry of Health through the Immunisation Section and the Health Promotion Department and the Office of Research, Projects and Statistics of the Ministry of Health, through the Department of Statistics. To support implementation, inter-institutional subcommittees will be revitalised (MINSA-Partners): (1) Technical Subcommittee; (2) Logistics Subcommittee; (3) Social Mobilisation Subcommittee and the (4) Finance Subcommittee, to support project implementation and monitoring.*  *At the level of civil society, the NGO Core Group, which includes NGOs supported by USAID and the Bill and Melinda Gates Foundation (AFRICARE, CRS, WORLD VISION, CARITAS and ASODER) will implement the information, education and communication activities in accordance with the guidelines of the MINSA Health Promotion Department, in coordination with the Angola Red Cross, Rotary International and technical support from UNICEF.*  *At the decentralised level, secondary implementation entities**of the HSS-Gavi will be the Provincial Health Directorates through the Provincial Public Health Departments and, at the Municipal level, the Municipal Health Departments. These entities will monitor the implementation of activities and the use of funds and assets of HSS-Gavi by the Health Units within the scope of the project. Monthly meetings are planned at the provincial level and every two months at the municipal level.*  *The Managing Entities of the funds from HSS-Gavi (funds recipient) will be the WHO and UNICEF.* |

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| 5. Acronyms | |
| *Provide a full list of all acronyms used in this application.* | |
| **Acronym** | **Acronym meaning** |
| REM/EC | Reach Every Municipality and Every Community |
| ADECOS | Health and Community Development Agents |
| ICC | Interagency Coordinating Committee for the EPI |
| CECOMA | Procurement Centre for Medication and Equipment |
| HC | Health Centre |
| NDPH | National Directorate of Public Health |
| PHD | Provincial Health Directorate |
| DQS | Immunisation Data Quality Assessment |
| DQS | Immunisation Data Quality Self-assessment |
| Gavi | Global Alliance for Vaccines and Immunisation |
| GEPE | Office of Research, Planning and Statistics |
| IMG | Immunisation Systems Management Group |
| QI | Quality Index for monitoring systems |
| MINSA | Ministry of Health |
| MLM | Course for EPI Mid-Level Managers |
| NGOs | Non-governmental Organisations |
| NITAG | National Immunisation Technical Advisory Group |
| EPI | Expanded Programme for Immunisation |
| *HSS-Gavi* | Gavi Project for Health System Strengthening |
| MHDP | Municipal Health Development Program |
| NHDP | 2012-2025 National Health Development Plan |
| cMYP | 2016-2020 Comprehensive Multiyear Plan for Immunisations |
| PHDP | Provincial Health Development Program |
| HO | Health Outpost |
| SDD | Solar Direct Drive Equipment |
| HIMS | Health Information Management System |

# Part B: Background information

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| 6. Description of the National Health Sector *(Maximum 1 page)* |
| *Provide* ***Attachment #8****: NHSP or equivalent and reference, which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*  *In the past decade, the Angolan Government has made significant efforts to create conditions and facilitate the means to strengthen the National Health System, a situation that was helped by rapid economic growth and significant political willingness. Peace has provided for the reconstruction of the infrastructure of the public health network after more than 3 decades of war, which represented one of the primary advances made by the Country. In this respect, investments were made in rehabilitating, building, equipping health structures, creating new jobs for health care personnel and training human resources in health units. Notwithstanding the progress made, the public network is sparse and is unequally distributed, favouring urban areas and the coastal and central provinces, which are the most populated areas. It is estimated that approximately 20-30% of the population does not have geographic access to basic health services. Accessibility to health services is made more difficult by the dispersion and low density of population in the provinces of Eastern and Southern Angola. There are populations of persons returning after the conflict in areas without health services in several provinces of the country, and new instances of rapid growth without nearby services in the capital city of Luanda.*  ***There are four National Health Service levels of management****: (a) central level, consisting of the regulatory central structure of the Ministry of Health; (b) operational and technical support provincial level, consisting of Provisional Health Departments that report on a technical basis to the Ministry of Health and on an administrative basis to the Provincial Government; (c) operational municipal level, consisting of Municipal Health Departments that report to the municipal government; (d) local level, consisting of health units that report to the municipal government. The provincial and municipal central level has technical personnel responsible for EPI, including EPI supervisors, a supervisory and logistic technician. The EPI central level technical team is very small, limited to 2 physicians, 2 supervisory nursing technicians, 2 logistics personnel and two data managers.*  ***The network of health care facilities*** *of the National Health Service is organised into three levels of treatment that provide public health care services via 2,499 health care facilities (Statistical Health Annual Report/MINSA 2014).* ***The primary health care level*** *comprises 1,790 health outposts (HOs) and 461 health care centres (HCs) that respectively constitute 72% an 18% of the health services network. Notwithstanding the Health Outposts being numerous, they are dispersed in a broad rural area of the Country and several peripheral urban areas; they are poorly structured and in general have only 1 to 2 nurses to offer the basic outpatient package, including immunisations. The Health Centres are generally located in urban areas; they provide outpatient primary care, including immunisations and emergency hospitalisation. Many HCs have advanced teams perform immunisation activities.* ***The secondary level*** *is comprised of the polyvalent urban hospital network which includes 166 municipal hospitals and 29 provincial hospitals and 41 physical therapy services and other unclassified facilities that amount to 9.5% of the total health services; municipal hospitals provide outpatient and hospital care and some of them perform general surgery. With regard to routine immunisation, they immunise at permanent outposts and some of them have advanced and mobile teams. The provincial hospitals are better equipped, they have more qualified human resources and have greater capacity for resolution and offer routine immunisation.* ***The tertiary level*** *includes 12 differentiated hospital units at the national level that provide care in medical and surgical specialties. They include qualified personnel from the health system. Immunisation is carried out only and maternity centres and pediatric hospitals. The installed capacity of the national health service for routine immunisation is not fully used.*  ***The private sector*** *of health care services includes 82 clinics, 614 medical centres, 214 physician consultation offices, 84 specialised medical offices and 824 nursing outposts (Health Statistics Annual Report/MINSA 2014). Its importance is growing in urban areas, but it is not significant in rural areas. The majority of the services is for-profit and they are located in Luanda. There are relatively few NGOs and religious health services. The NGOs and the private sector have an increasing importance in routine immunisation, especially in Luanda.*  ***Human resources.*** *The National Health Services (SNS) is suffers from quantitatively and qualitatively insufficient human resources at all levels, and the same are inequitably distributed by levels, regions and urban and rural areas, in part caused by displacements from the war. Ninety percent of the health care facilities are primary care facilities and account for approximately 20% of health care personnel. The SNS has 51,342 employees (Health Statistics Annual Report / MINSA 2014), of which 1,668 are physicians (3%), 28,665 are nurses (56%), 4,453 diagnostic technicians (9%) and 16,556 administrative and service employees (32%). There is a shortage of physicians, with only 0.7 physicians per 10,000 residents. In order to make up for the deficit in personnel at the operating level additional temporary personnel are hired, many of them not trained in health care programs. The Government is promoting the rapid development of public and private health sciences schools in several provinces that may gradually cover the major gap in training that exists. In addition, the level of competency of nursing personnel is to be increased through policies for the requalification of personnel, which offer opportunities in all the provinces to professionalise human resources. In general, vaccinators are the least qualified personnel in the health system, since qualified personnel work in assistance jobs.*  ***Supply and logistics for medications and vaccines.*** *MINSA has established a national essential drug policy that includes vaccines, creating the basis for a significant improvement in drug management. The Procurement Centre for Medication and Equipment (CECOMA) is an institution under MINSA created in 2013, that is responsible for the centralised procurement and distribution to the provinces of essential program drugs, including vaccines, syringes and safety boxes. During missions to prepare the transition plan (Oct. 2014) and joint assessment with the Gavi Alliance (Sept. 2015), it was noted that CECOMA has limited technical capacity and experience, therefore procurement and vaccine distribution procedures as well as coordination with the immunisation program need to be strengthened. Interruptions in vaccine inventory were attributed to delays in the procurement process. Vaccines are procured through laboratories that are prequalified by WHO. Vaccines are distributed together with medications using refrigerated vehicles leased by CECOMA.*  *With regard to procuring cold chain equipment, MINSA defined a policy for purchasing equipment from a list approved by the WHO/UNICEF. Since 2015, following the WHO-AFRO recommendation, purchase s have been oriented toward SDD solar energy refrigerators because of their good results, ease of maintenance and long service life, and i tis planned to gradually replace gas equipment with solar energy equipment. Since the MINSA budget for cold chain purchase s is decentralised down to the municipal level, purchase s were not always according to recommendations, which is why this Project proposes support for regulating the use of funds.*  ***The Health Information System (SIS)*** *covers the treatment levels: Primary, secondary and tertiary. Information is transmitted by levels, starting with the health units that generate the data to the central level of MINSA. The Office of Research, Planning and Statistics (GEPE) of MINSA is the entity appointed by INE to collect, analyse and generate health statistics. Data on the routine provision of health services, program activities, epidemiological monitoring and administrative and financial data management have not yet been provided; they follow parallel flows, with little feedback and analysis. In general, data reaches the programs with a considerable delay, and they are incomplete, low-quality and they are rarely used for making decisions. The lack of reliable statistics is a serious problem for the calculation of indicators, a situation that has not yet been corrected, since the final national population census data for 2014 is still pending. The routine immunisation data subsystem has monthly frequency and follows the flow through levels until reaching the EPI central level, where data is processed and feedback is made.*  ***Community Health Agents (ACS), traditional authorities and religious leaders*** *have played a relevant role in the organisation and implementation of immunisation campaigns and to a lesser extent in routine immunisation and other health activities. Some Provincial Governments started making monthly payments to ACS but they could not be maintained in the long term. The President is prepared to promote a sustainable national policy for Health and Community Development Agents (ADECOS) that started in 2015 with the training of trainers in order to later train community agents at the local level. This training is intended to close gaps identified in the continuity of initiatives by various health programs and integration with other sectors in order to mobilise communities to promote their own health.*  ***Health funding.*** *According to the national health report cited by the WHO Health System Financing Country Profile, in 2013, 91% of funding for health expenses in Angola came from domestic funds; 67% were paid by the Government and 24% directly by families. The remaining 9% was paid with funds from external sources. During the period of 2009 to 2014, total health expenses tripled: from 100,121 million Kwanzas in 2009 to 346,734 million Kwanzas in 2014. This increase represents an increase from 1.70% to 2.70% of GDP. However, total health expenses remained relatively stable as a proportion of the Overall Government Budget, with an average of 4.58% for the same period. Even if the general state budget for health is increased in absolute terms, there are still problems in paying the co-financing for new vaccines.*  ***Legal and regulatory context.*** *The State Political Constitution of 2010, in Article 21, Line 4, specified the promotion of policies that make primary health care universal and free to be a fundamental duty of the State. Furthermore, the “General Regulation on Health Care Facilities” defines Primary Health Care as the essential package of preventive and curative services offered in the basic health services network, including immunisations. The National Health Policy enacted by Presidential Decree No. 262/10, in Article 42 declares the principles of universality, quality, humanisation and responsibility as being the basis for health care interventions.* |

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| 7. National Health Sector Plan (NHSP) and relationship with cMYP (*Maximum 2 pages)* |
| *Describe the relationship of the cMYP to the national health strategy.*  *Provide:* ***Mandatory******Attachment #8****: NHSP and* ***#11:*** *cMYP; and if available:* ***Attachment #18****: Joint Assessment of National Health Strategy (JANS); and* ***Attachment #19****: Response to JANS.*  *The* ***2012-2025 National Health Development Plan (NHDP)*** *was prepared by a Multisectoral Commission, created by Order No. 84/11 of the President of the Republic of Angola is a strategic instrument intended to implement the guidelines established in the Angola 2025 Long-term National Development Strategy, and in the National Health Policy and the reform of the National Health System. The NHDP has its decentralised expressions in the Provincial Health Development Plans (PHDP) and the Municipal Health Development Plans (MHDP) that were prepared collaboratively at sub-national levels.*  *The NHDP intends to confront the health priorities, which include: (a) An increase in health coverage and sustainable maintenance of health care units; (b) Improvement of the reference and counter-reference system among the three levels of the National Health Service; (c) An increase in technical capacity, the number of human resources and an improvement in the distribution of personnel in rural and peripheral urban areas; (d) An improvement in the health management system, including information systems, logistics and communication; (e) An increase in financial resources and the adjustment of the financing model; and (f) An increase in access by the population to potable water, sanitation and power.*  *The strategic guidelines of the NHDP are intended to promote: (a) The provision of quality health care, related to promotion, prevention, treatment and rehabilitation, improving coordination between primary health care and hospital care; (b) Implementation of the promotion and provision of health care at the community level; (c) Revitalisation of municipal health services in line with the global orientation of the governance process and gradual decentralisation, which guide clearer decision-making by individuals and improve the efficiency with which services are provided; (d) Participation in the transformation of social health determinants and the promotion of national and international partners, in favour of reducing maternal and child mortality and programs to combat major endemics; (e) Monitoring and assessment of the NHDP implementation, including the performance of the sector, through the health management information system (HMIS) and special studies.*  *The NHDP presents ambitious objectives in all domains of the National Health System, including improving the fight against communicable and chronic non-communicable diseases, care for mothers and children, improvement of access to services and the reference system for complicated cases. The NHDP is comprised of 9 programs, which are subdivided into 20 subprograms and 46 projects.*  *The Vaccine-preventable Disease Control and Prevention Program (EPI) is the NHDP Project 1 of Program No. 1 to Prevent and Fight Diseases. Immunisation, by its straightforward nature, relatively low cost and high effectiveness, is deemed a priority intervention of the NHDP. The immunisation coverage goals for 2025 established by the MHDP are to attain 95% national immunisation coverage for all antigens on the national immunisation calendar and 90% coverage for all antigens in all municipalities of the country. The Penta3 coverage indicators for children less than one year of age.*  *The 2015-2020 Multi-year Immunisations Plan (cMYP) is in line with the NHDP in terms of policy and strategy guidelines. Both plans promote the priority of immunisation and are able to create conditions for an increase in coverage and an improvement in equity of access to immunisation. Better distribution of personnel in peripheral urban and rural areas specified in the NHDP will encourage the provision of immunisation services in these areas that were previously neglected. Furthermore, both plans comply with the new roadmap of the 2010-2020 Global Vaccine Action Plan (GVAP) that is intended to accelerate the prevention of deaths via more equitable access by the population of all communities to existing vaccines and gradual access to new vaccines. The MHDPs provide for the introduction of the Pneumo13 vaccine in 2013 and the Rotavirus vaccine in 2014, a situation that was accomplished by the Country as planned. Introduction of the HPV vaccine in 2017 is planned in the NHDP.*  *The cMYP intends to reverse the stagnation in national coverage and overcome the persistent gaps in coverage between municipalities, urban-rural areas and populations of different socio-economic status. The goals of the cMYP for 2020 are to achieve 90% or more immunisation in coverage for children less than one year of age at the national, provincial and municipal level for all antigens: BCG, Polio, Pentavalent (DTP. Hib, HepB, Pneumo13, Rotavírus, Measles, Yellow Fever, HepB at birth and TT-2+ in pregnant women and introduction of the Inactivated Polio Vaccine (IPV).*  *The MHDP defines the delivery of immunisation at all health care facilities in the country as a priority. Consistent with this guideline, the vision of the 2015-2020 cMYP characterises immunisations as essential to the strengthening of the health system, and therefore they must be offered free of charge at all public and private health care facilities in an on-going, sustained manner. The prioritisation of improvements in the efficiency of operational components of the health system to increase access, for the use and quality of maternal-children's health is mentioned at several points in the NHDP. The cMYP defines as priority activities the expansion/reinforcement of the network of fixed immunisation points by providing cold chain equipment and theoretical-practical training and supervision to test skills for personnel at the health care facilities, and to ensure visits by advanced teams planned by the health care facilities to communities or districts that do not have health services. In the field of human resources, the NHDP intends to eliminate asymmetries between rural and urban areas, and to ensure functional coordination between levels, which apparently will facilitate the implementation of immunisation coverage expansion activities.*  *In the context of logistics the MHDP intends to ensure the on-going availability at the operational level of safe, effective and quality essential medications (including vaccines) at the best prices, and to promote the rational use of the same by health care professionals and by consumers, strengthening the capacity of the Medication and Equipment Procurement Centre (CECOMA) to plan and carry out public bidding processes for the regular supply and acquisition of safe, effective, good quality pharmaceutical products, prequalified vaccines and the construction and improvement of the network of provincial warehouses that include cold rooms for vaccines.*  *The cMYP is intended to contribute to providing information for procuring vaccines from suitable vendors pre-qualified by WHO that ensure quality processes and transparency. To ensure at the central level a permanent reserve inventory of vaccines and material for regular supply every 6 months, and to increase the short-term positive cold chain storage capacity at deficient provincial and municipal warehouses, in coordination with CECOMA.* |

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| 8. Monitoring and Evaluation Plan for the National Health Plan *(Maximum 2 pages)* |
| ***Provide background information on the country M&E arrangements.***  *There is as het no general monitoring and assessment plan for the NHDP. The Research, Planning and Statistics Office of MINSA, with support from USAID, is in the process of preparing a monitoring and assessment plan for the programs, sub-programs and projects of the NHDP. The European Union is providing support for the development of a single health information system by designing and implementing a national information platform capable of aggregating local statistical data that supplies the national indicators for the health sector. Additionally, MINSA has sent a project to the Global Fund to improve the unified system for monitoring and global assessment of MINSA activities during the period of August 2016 – August 2018.*  *Currently, performance indicators for the programs are monitored separately by the Central Entities of the Ministry of Health and by the technical teams from the programs. Periodically, the National Public Health Directorate, at its Management Council meetings, monitors the progress of the activities and indicators of the programs for which it is responsible. A monthly and quarterly integrated report on the activities of the NHDP including performance indicators for the priority programs, including immunisations, is prepared by MINSA and sent to the Office of the Vice President of the Republic.*  *Twice a year, the Ministry of Health organises meetings of the MINSA Advisory Council, with the participation of directors from the central entities of MINSA, provincial health directors, several municipal directors and heads of some programs, including the EPI, to assess the progress of priority programs and activities and to define technical and management guidelines. These meetings are very useful for obtaining feedback from the provinces and municipalities and for the Government officials to take corrective actions.*  *In practice, the most efficient mechanism for monitoring and evaluation of activities are meetings of the Interagency Coordinating Committee (ICC) of the EPI, coordinated by the Minister of Health, which every other week/monthly brings together representatives of the WHO, UNICEF, USAID, CORE Group, the Red Cross of Angola, Rotary International, Society of Pediatrics, the Project for Strengthening Municipal Health Services from World Bank, MINSA technicians and partners. EPI indicators are periodically presented at the ICC meetings (coverage by antigen, by provinces, DTP1-DTP3 dropout rate, distribution of the absolute number of non-immunised children by province and municipality and the trend compared to the previous year). In addition, during the periodic meetings of the Country Coordinating Mechanism (CCM), which integrates projects funded by the Global Fund, the progress of activities in the Malaria, Tuberculosis and HIV/AIDS is monitored. MINSA health teams from agencies, NGOs and other sectors participate in these meetings.*  *From 19 December 2013 to 16 January 2014, an independent team (CORE Group) conducted immunisation coverage surveys in all provinces, using the WHO methodology of 30 clusters in each survey and seven children from 12 to 23 months old in each cluster, for a total sample size of 3,764 children. The consolidated results of this survey were sent to WHO/UNICEF/HQ, which performed the final analysis of the results, estimating national DPT-3 coverage of 73% compared to 80% and 93% DTP3 coverage obtained with administrative data from 2014 and 2013 respectively, which shows a significant discrepancy in the estimate.*  *Given the routine data integrity and quality limitations of the MINSA information system, the National Statistics Institute and USAID, Unicef and WHO support a Multiple Indicator Survey of a national sample of families (MICS-2015) is to be implemented that will provide reliable information on infant mortality, nutrition as well as coverage of maternal-infant health, including immunisation. The results will be available in the second quarter of 2016.*  *The Gavi Joint Annual Health Sector Review was performed in Angola from 31 August to 4 September 2015* *by a team consisting of Ministry of Health technicians, representatives of civil society organisations, domestic and international partners and a representative of the Gavi Secretariat. The main observations were as follows:*   * *Goals achieved in 2014: Penta3 coverage (DTC-HepB-Hib3) 80%; PCV13 (3rd dose) 61%. Rotavirus Coverage 2nd dose 18%; 47% of municipalities in the country achieved > 80% DTC-HepB-Hib3; dropout rate between Penta1 (DTC-HepB-Hib1) and Penta3 (DTC-HepB-Hib3) was 20%; 78 municipalities in the country achieved DTC-HepB-Hib3 coverage of less than 80%; 27 municipalities in 11 provinces had DTC-HepB-Hib3 coverage of <50%.* * *Existence of an Interagency Coordinating Committee (ICC) that meets regularly and guides actions. The National Immunisation Technical Advisory Group (NITAG) is in the process of implementation.* * *Existence of human resources for the immunisation program at all levels of immunisation service. But there is also a large deficit in the quantity and quality of technicians for the program at all levels and there are frequent transfers of technicians trained in EPI to other areas and programs.* * *All levels have cold chain, but at some locations, the capacity is insufficient to store local needs. There are cold chain and logistics technicians at all levels, but they are not trained, which results in a lack of regular equipment maintenance and repair. In some municipalities, equipment was purchase d outside of WHO recommended standards.* * *Immunisation is provided throughout the country fixed immunisation points, advanced and mobile teams; complemented by supplemental immunisation activities (campaigns against polio, measles, tetanus, administration of Vitamin A and Albendazol). The number of health units that provide immunisation service increased from 687 in 2010 to 1323, form a total of 2499 public sector units in 2014. Despite this significant progress, many neighbourhoods and communities lack easy access to immunisation. This is why the fixed strategy is being supplemented with advanced and mobile teams. These complementary strategies have not been fully performed due to the lack of means of transportation and support subsidy.* * *The MINSA and provincial Planning and Statistics Office is responsible for managing health information. All provinces have Cuban cooperation support for collecting information and then sending it to the central level. The immunisation program has 3 technicians at the central level for managing epidemiological and immunisation information.* * *At the municipal and Health Unit level, there is a data collection system. But there is a delay in sending information from the municipal level to the central level due to the lack of resources (transportation, Internet.). There is insufficient data analysis and use for timely decision-making at this level.* * *There is a communication and social mobilisation plan at the central level. Materials were also prepared for information, education and communication (IEC). This plan was adapted in relation to the reality of each province. Due to difficulties in financial resources, implementation of the plan at the municipal and Health Unit level is deficient or non-existent.* * *As of 2011, Angola began the graduation process within Gavi regulations; in 2014, a transition plan was prepared for the 2015-2017 period, to be financed by the Government and Gavi alliance members. There was a delay in implementing the graduation plan due to a delay in receiving Gavi funds, although other sources of financing were used to implement some key activities provided in the plan.*   *The principal recommendations were:* *a)* *to guarantee financing for the immunisation program and payment of the co-financing for new vaccines that are delayed and for upcoming years; b) to strengthen and train human resources; vaccine and immunisation material management and improved coordination between the EPI and CECOMA; c) to prepare and implement a plan to improve immunisation indicators in areas with low coverage levels; d) to strengthen implementation of mobile and advanced strategies in areas with the highest number of non-immunised children; e) to strengthen the cold chain capacity and increase the number of health outposts with immunisation activities.* |
| *Provide* ***Mandatory Attachment #9:*** *National M&E Plan (for the health sector/ strategy***)*,*** *as well as any sub-national plans, as relevant****.*** *If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*  *If available, provide* ***Attachment #16:*** *Data quality assessment report;**and* ***Attachment #17:*** *Data quality improvement plan.* |
| ***Pooled fund*** *applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.* |

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| 9. Alignment with existing results based financing (RBF) programmes (where relevant) *(Maximum 1 page)* |
| *Indicate whether your country will align HSS support with existing results based financing (RBF) programmes.*  *If yes, provide* ***Attachment #30:*** *Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.*  ***Angola did not participate in the Results-based Funding (RBF) program.*** |

# Part C: Application details

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| 10. Health System Bottlenecks to Achieving Immunisation Outcomes *(Maximum 3 pages)* |
| *Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach* ***Optional Attachment 33:*** *Health system bottleneck analysis.*  *The factors and bottlenecks of the health system that prevented attainment of better results in terms of quality of coverage and equity in routine immunisation were identified during the External International Assessment of the EPI conducted in July of 2014, the Post-introduction Assessment of the Pneumo13 Vaccine conducted in May 2014 in 5 provinces of Angola, the National Vaccine Coverage Inquiry (IVAC-2013) which investigated the reasons for non-immunisation in the 18 provinces of the Country, the joint assessment of the EPI by the Gavi Alliance Mission conducted in October 2015 and discussions with EPI technicians from the central level in provinces and municipalities during the annual assessment meeting for 2015. Many of the bottlenecks identified were recurring and required corrective actions to improve the efficiency of the program, cover unserved populations and reduce inequalities.*  ***Insufficient supply of quality immunisation services in the public health system.*** *The lack of full use for immunisation of the installed capacity of the public health system is considered a critical problem of the system; only 63% or 1,323 out of 2,090 health care facilities with permanent immunisation capabilities perform routine immunisation. The scarcity of permanent immunisation outposts was repeatedly mentioned by technicians from the provinces as a factor in low coverage. The IVAC 2013 inquiry showed that 34% of mothers of non-immunised or not fully immunised children indicated as a reason for non-immunisation “the immunisation location is very far” and 69% of them mentioned that “it is necessary to wait a long time at the immunisation centre.” The 2015-2017 Gavi Graduation Plan includes an increase in the number of permanent immunisation outposts in rural and peripheral urban areas to be a primary challenge for improving equality of access to immunisation. The lack of immunisation in health services is primarily due to the non-availability of functional cold chain equipment since much of the equipment is obsolete, requiring replacement, as well as health care facilities that do not have this equipment. The scarce human resources and deficiencies in personnel management, vaccines and materials contribute to the lack of immunisation. The 2016-2020 cMYP includes the expansion of the permanent immunisation network to a more economical and sustainable immunisation strategy.*  *The weaknesses in the quality of health care treatment are based on the structure of human resources in the public health sector, that predominantly use poorly qualified nursing personnel, and there are few trained medical and administrative professionals. Lesser qualified personnel are found in the primary health services network due to the fact that many of them were community agents, absorbed and retrained in the past by the health system. The weaknesses in management and treatment were revealed in the international assessment of the EPI in 2014, which showed significant gaps in knowledge of the program by operating personnel from the health units and supervisors at the sub-national level, and by the IVAC-2013 qualitative survey of families in which 72% of mothers of non-immunised or not fully immunised infants stated that “nurses are not able to treat people", 43% note that "on the immunisation date for the child, there were no vaccines," 29% stated that "on the immunisation date for the child the vaccinator was not there," and 15% of those surveyed noted that the "immunisation schedule was not convenient".*  *In order to introduce new vaccines, MINSA, with the support of Gavi, WHO and Unicef conducted short, cascade trainings for personnel involved in immunisation at all levels, since due to the high level of rotation of personnel and the low level of many officials, the benefit was low, requiring gradual training processes, that were appropriate for the personnel of the health services network, such as the modular packages of the Mid-level Management Program (MLM) for the EPI for supervisors and the Practical Immunisation package for personnel at health care facilities.*  ***Insufficient immunisation in communities with difficult access to health services.*** *Due to the limited national network of health services, the dispersal of the population in many of the provinces and the nomadic aspect of several population groups, the stationary strategy needs to be supplemented by advanced and mobile teams that provide immunisation and other health interventions for populations that lack access to health services. Prior to 2010, the advanced activities were highly dependent on external funding from partners and backers who supported immunisation in several municipalities. Since 2010, the costs of these activities have been covered for all municipalities using Primary Health Care funds, disbursed by the national government (60% of the MINSA budget) to municipal governments as part of the sustainable reinforcement policy for the municipal health system. In practice, there are difficulties in timely availability of funds.*  *Notwithstanding the limitations on funds and the insufficient transport resources, 156/166 municipalities in 2013, and 158/166 municipalities in 2014 implemented the advanced and mobile strategy with varying degrees of quality, allowing the application of 20-21% of the total Penta3 doses administered in the Country. In municipalities with few permanent outposts, up to 47% of doses applied were given by advanced and mobile teams. Nevertheless, not all the health care facilities of municipalities use these strategies; during the external international assessment of the EPI conducted in 2014, it was noted that only 69% of the health care facilities evaluated used advanced or mobile strategies, neglecting communities in which services are difficult to access.*  *The decentralisation of financial resources at the municipal level is one strength of the health system, because it largely facilitates direct access to funds. Notwithstanding the progress achieved, there is the risk that the effectiveness of this important government strategy will be lost, due to the lack of regulations and control over the use of decentralised resources.*  ***Insufficient supervision and monitoring of activities at the operational level.*** *Formative supervision which is critical to improving the performance of EPI personnel and of local health care teams have many gaps in their implementation, primarily at the local level. The introduction of new antigens into the immunisation calendar requires monitoring and adjustments in the field to ensure the effective conservation, use and recording of these interventions. The post-introduction assessment of the Pneumo13 vaccine showed that there was sparse compliance at the local level. The supervision of personnel from the provinces is carried out by technicians from the central level of MINSA and partners once or twice per year, many times taking advantage of the immunisation campaigns. The supervision of the municipal teams is rare and many municipalities are left without supervision. The personnel from health care facilities who perform immunisation receive irregular supervision from municipal personnel and from the immunisation teams, active oversight from the municipality and the province.*  *The primary reasons for which no supervision was conducted are the scarcity or lack of transport resources and the failure to have funds available for payment of per diems or leasing vehicles at some levels. The central level of the EPI has received support from WHO and Gavi (new vaccine introduction funds) in order to carry out supervisions. With funds from the Graduation Plan, one vehicle is in the process of being purchase d for the central level. The municipal level has resources in the form of decentralised funds to rent vehicles or motorcycles and for the payment of per diems, however these funds are not always available. The provincial level is under-funded, and requires a great deal of support, since it has scarce resources and has the responsibility of conducting supervision, transporting vaccines and immunisation materials.*  ***Insufficient cold chain, lack of maintenance of equipment and deficiencies in vaccine logistics and management***  *CECOMA has very little personnel, limited experience and technical capacity, which is why vaccine procurement and distribution procedures are not efficient. CECOMA procures traditional vaccines from local intermediaries and UNICEF purchase s new vaccines. The distribution of all vaccines to the provinces is carried out via private companies contracted by CECOMA for refrigerated transport of vaccines together with medications according to quarterly plans that are adjusted monthly by the national EPI, in consultation with the provinces. The Gavi Graduation Plan provides for international technical support for CECOMA.*  *The supply of vaccines by municipal warehouses is a bottleneck due to the lack of provincial transport resources and the insufficient storage capacity in many municipalities, which requires very frequent resupply. Deficiencies in the quantities of vaccines distributed at time create avoidable inventory rotation. In general, the municipalities collect their vaccines and materials from the province, taking advantage of any travel conducted for other reasons. The distribution of vaccines to the health units is carried out based on consumption. During the international assessment of effective vaccine management (EVM-2014) insufficiencies were detected in storage capacity for vaccines and materials and failures in daily temperature control, monitoring of vaccine wastage and vaccine inventory control.*  *The shortage of equipment and cold chain resources at new health care facilities and those without operational equipment is a major bottleneck that prevents taking advantage of the installed capacity that may expand access by rural and peripheral urban populations that comprise nearly 27% of the health care outposts and centres of the Country. The lack of maintenance and spare parts for cold chain equipment has contributed to reducing the service life of such equipment.*  *The central vaccine warehouse was built in 2013 with a net capacity of 150 m3 that would be sufficient through 2025. Ten of the twelve provinces that require cold rooms gradually installed this equipment between 2012 and 2015, with only Huila missing a cold room, which which was not purchase d due to the financial crisis. The other 6 provinces with lower target populations require only supplementation with cooler chests. Of the 166 municipal warehouses, nearly 60% require refurbishment since the RC50 EG mini cooler that was the standard equipment for health care facilities is not large enough to hold new vaccines for medium and large municipalities.*  *The introduction of new vaccines. Pentavalent in 2006, Pneumo13 in 2013, Rotavirus in 2014 and the introduction of the Inactive Polio Virus planned for 2016, created in a very short time the need for a major increase in positive cold chain storage capacity at the three levels of the health system, and furthermore they increased the complexity of logistics management for vaccines and the large volume of syringes and additional immunisation materials. Due to the high costs of cold chain infrastructure at the national and provincial levels and the high costs of standard refrigeration equipment for the services network, it was not possible to fully cover the shortage of cold chain equipment, even with Gavi support.*  *In most municipalities, the equipment is gas-operated, with interruptions in general supplies in some municipalities; this is why the gas equipment will gradually be replaced by SDD solar-powered cooler chests, the equipment recommended by the WHO.*  ***Insufficient educational communication and empowerment of mothers and guardians of infants.*** *During the post-introduction assessment of the Pneumo13 vaccine carried out in 5 provinces of Angola, the following were identified: lack of interpersonal educational communication between the vaccinator and mothers during immunisation, insufficient knowledge about new vaccines on the part of mothers, lack of informational material on vaccines in health treatment facilities and a lack of promotion activities by community activists. Various socio-anthropological surveys conducted by UNICEF in different cultural contexts in the country yielded similar results. Mothers of non-immunised or not fully immunised infants who were surveyed in the 2013 IVAC, when questioned regarding their immunisation knowledge, 61% noted that “they did not correctly know the times when they should take their children for immunisation", 19% of them noted that "they did not take their child to the immunisation outpost because the child was sick", or 16% of them noted that "immunisation was not important, because it did not protect children" and 10% said that "immunisation caused disease". As part of the Graduation Plan, the implementation of activities to reinforce interpersonal educational communication in 4 provinces of the Country are in progress. In order to promote the demand for immunisation, MINSA, in coordination with the Ministry of Communications disseminated informational messages promoting routine immunisation on radio and television in Portuguese and national languages.*  ***Poor quality of data and insufficient analysis and use of information.*** *The administrative data for routine immunisation, even though they are the most structured data in the health system, have problems, primarily with regard to opportunity, integrity and the reliability of the same. Estimating routine immunisation coverage has been made more difficult as well with the lack of reliable population data, because the recent national survey of the population was conducted in May 2014, 44 years after the 1970 census. The definitive results are still pending.*  *During the external quality audit of routine immunisation data (DQS 2014), results showed that in a majority of cases, accurate immunisation data is not reported. Over-reporting was observed primarily at the level of health care facilities; the primary causes were: Mathematical errors when transferring data and notation of non-immunised children as having been vaccinated. Only 11% of the facilities visited had accurate reports; 55% over-reported and 34% underreported doses of the Penta3 vaccine. At the municipal level, 46% of the 24 municipalities assessed accurately reported dose numbers; 29% overreported and 25% underreported. The primary causes of overreporting of data at the municipal level were mathematical errors when consolidating reports from health care facilities and incorrect filing, which did not permit verification of some reports. The primary cause of underreporting was the late receipt of reports from some health care facilities.*  *Relative to the quality of components of the monitoring system, at the level of health care facilities the overall quality index (IQ) was determined to be 55%; the components with the weakest scores were: Population knowledge, use of data, delay in report submission. At the municipal level, the Quality Index of 70%; the components with the lowest index were monitoring of vaccine wastage rate, timely notification of monthly reports; filing and use of routine immunisation data. Since 2014, in 8/18 provinces, self-assessment of routine immunisation data quality was conducted periodically as part of the IMG initiatives with improvement in the opportunity and reliability of the same. The Gavi Graduation Plan provides for training in data management and DQS surveys, as well as for purchasing computers.*  ***Interruptions in vaccine supply and insufficient financing.*** *Interruptions in the inventory of program medications, vaccines, medical supplies and reporting materials continue to be a challenge experienced by the health system. Significant interruptions in central inventory of traditional vaccines were relatively recent and sparse, and they were reflected throughout the health system. They were caused in part by the change in standards and procedures for procurement of vaccines that extended the procurement periods (Polio vaccine), scarce availability on the global market (yellow fever and BCG, delays in the payment of co-funding for new vaccines by Gavi. CECOMA’s limitations in purchasing processes will contribute to extending inventory interruption periods. No interruption in the inventory of syringes or safety boxes for disposal were reported.*  ***Inequities in access and use of immunisation services****. Access by the population to immunisation health services is not uniform; an initial barrier to access, and the most important one in Angola, is geography. Due to the large area of the country, unequal distribution of the health care network, the great dispersion of the population in many municipalities and scarce public transportation resources in rural areas, the distance of health services is a determining factor for potential access to immunisation. Despite having improved means of transportation, approximately 10-20% of the population does not have easy access to fixed health care services and therefore advanced and mobile teams are needed to immunise these groups. No cases of routine immunisation refusal or discrimination due to cultural reasons were reported except in small religious groups of people from Bas-Congo who refused immunisation. Refused or incomplete immunisation due to ignorance or fear of adverse effects from immunisation is of moderate importance and is encountered primarily in groups with limited education and the indigenous population, a situation that may be overcome by appropriate treatment and adequate interpersonal communication, which is still a problem in the service network. In general, the economic barrier is not an obstacle to immunisation since immunisation is free. On rare occasions, supervisors report isolated cases of collecting vaccines, situations that were resolved by the authorities. The economic barrier has gained importance in poor families due to the high cost of public transportation, which may be a determining factor for not immunising or not completing the immunisation schedule for poor families with several children. Functional barriers to immunisation of users visiting health care facilities are significant and are related to long wait times, poor treatment, lack of information, incomplete information, failures in the health care system, including the availability of personnel, vaccines and material. In recent years, at Gavi’s insistence, more attention was paid to the possibility that gender discrimination exists in immunisation, but no consistent information was found that shows this phenomenon in the immunisation name register. The national MICS survey that is underway will analyse coverage by sex.*  ***Limited management capacity at the central level***  *Angola requires support to increase administration and to facilitate compliance with the guiding role of the Ministry of Health. The establishment of an independent entity (NITAG) to support the establishment of policies and strategies to increase benefits for the population and the sustainability of the various components of the immunisation system and on the other hand the development of mechanisms to improve the coordination and standardisation of the various projects for institutional strengthening so as to obtain greater efficiency in the use of available resources from external cooperation.*  *Nevertheless, the decentralisation policy for financial resources is of great strategic value and support for implementing health activities at the local level. The health teams in the provinces surveyed believe that the lack of regulations for using decentralised financial resources directly by municipal governments for operational Primary Health Care activities impede its best use, since with available resources, the efficiency of the municipal health system can be improved to better provide immunisation to populations without health services and ensure logistics for transportation, cold chain and supervision activity of Primary Health Care in a sustainable manner over the short-, medium- and long-term.*  *The International Assessment Report of the EPI for 2014 notes the scarcity of human resources and the insufficient numbers of qualified personnel in the public health sector as factors limiting the management of programs at all levels of the system. At the central level, public health programs have very scarce qualified personnel which makes it difficult to provide technical support and monitor activities in the 18 provinces of the Country. At the central level, the Expanded Program on Immunisation has a technical team is limited to 2 physicians, 2 supervisory nursing technicians, 2 logisticians and two data managers. CECOMA also lacks experienced, qualified personnel, and both entities need additional technical assistance, especially in logistics, cold chain and finance to better perform their duties.* |
| ***Pooled fund*** *applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.* |

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| 11. Health system bottlenecks to be targeted through Gavi HSS support *(Maximum 2 pages)* |
| *Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.*  *Support for Gavi Health System Strengthening will be focused on 11 of the 18 provinces of the Country and on 97 of 161 municipalities. Provinces were selected based on the following criteria. Low immunisation coverage, less equality measured based on the proportion of municipalities in each province with Penta3 coverage of less than 80%, provinces with the greatest dispersion of the population and fewest health care facilities per resident as an indirect access indicator. Another important criterion was the absolute number of non-immunised children per province with the potential for changing national coverage.*  *In this manner, the eleven provinces with the poorest indicators were selected; they in the aggregate account for 71% of the national population (25,090,417 for 2015) and 67% of the absolute number of non-immunised children in the country in 2015 (390,610). The selected provinces are: Cunene, Namibe, Malange, Zaire, Huila Cuanza Sul, Moxico, Cuando Cubango, and Luanda (only the municipalities of Viana, Cacuaco and Belas), the latter due to their rapid population growth due to recent migration, poor health structure and since they account for nearly 20% of the non-immunised individuals in the Country.*  *In each province except Luanda, all of the municipalities (97) were considered, since previous projects that selected only some municipalities had difficulties in implementation due to a lack of involvement at all levels of the health system and discouraging municipalities that are not supported. Basic training and supervision activities will be performed in all municipalities, but the first to benefit from them with greater monitoring frequency will be the municipalities with low access and low usage. Priorities may change in relation to the dynamics of progress to achieve goals. Municipalities with the greatest absolute number of non-immunised children will get special attention. Thirty municipalities were already prioritised to be equipped with motorcycles since there are many difficult to access towns.*  *The problems prioritised for intervention in this Project are interrelated and are critical to improving sustainable routine immunisation coverage:*   1. *Insufficient supply of quality immunisation services in the public health system.* 2. *Insufficient cold chain, lack of equipment maintenance and deficiencies in vaccine logistics and management; (support for the vaccine supply component is contained in the Graduation Plan;* 3. *Insufficient educational communication and empowerment of mothers and guardians of infants.* 4. *Poor quality of data and insufficient analysis and use of information;* 5. *Limited management capacity at the central level of MINSA.* 6. *Insufficient supply of quality immunisation services in the public health system.*   *In order to expand the offering of quality immunisation services, improvements in the use of installed public sector capacity and expansion of immunisation coverage to populations with little access to stationary health services is planned, by means of: 1) supplying solar-powered cold chain equipment primarily at the level of rural and peripheral urban health care facilities that do not have this equipment. 2) Gradual training of nursing personnel in the modular “Immunisation in Practice” package that will improve technical skills, micro-planning, resource management and the treatment of health care facility users; 3) Provision of vehicles to allow systematic formative supervisions to monitor and support the development of human resources; and 4) Supporting MINSA for regulating and controlling the use of decentralised financial resources by the Ministry of Health to the Municipalities for primary health care (funds for advanced and mobile teams and supervision, among other items; 5) Strengthening of the operational capacity of municipalities with difficult to reach populations, by the procurement of motorcycles in order to supplement local efforts.*  *As part of the implementation of the Gavi Graduation Plan, with support from WHO, trainers from the central level and 12 provinces of the country have already been trained, in an intensive Mid-Level Management (MLM) course for the EPI, lasting 2 weeks, for 40 EPI supervisors from the central levels, nursing and medical schools and technicians from 12 provinces. Two other courses are being prepared for provincial and municipal trainers, also funded by Gavi. In this manner, national capacity is being created to improve program management and have the human resources to correctly train personnel from health care facilities in the immunisation package in practice with funds from this project.*  *In order to monitor supervisions and provide informational feedback, innovation is planned, by training technicians from the central level and the provinces, selected for the procurement of smart phones and the installation of the Magpi app and GPS for collection and real-time transmission of operational data obtained in the field during supervisions at the provincial and national levels, and for support for the ongoing operation and maintenance of the system.*   1. ***Insufficient cold chain, lack of equipment maintenance and deficiencies in vaccine logistics and management***   *The improvement of the system for the supply, transport and effective management of drugs, vaccines and vaccination material in the health system will be supported by strengthening the technical capacity of CECOMA considered in the graduation plan and the contracting of a domestic consultant for technical support that will be carried out with the funds from this project (Objective 5) project).*  *The increase in the cold chain network at primarily rural and peripheral urban health care facilities in 11 provinces through SDD solar equipment as well as the procurement of solar equipment for municipal vaccine redistribution warehouses. One cold room will also be procured for Huila so as to increase the cold chain vaccine storage capacity and for the training of provincial and municipal logisticians for preventive maintenance and repair of existing equipment as well as the improvement of supply chain oversight will contribute to improving vaccine supply logistics. Provincial logistics will be trained in the Vaccine Management Tool.*  *The last national procurement of cold chain equipment for health care facilities was carried out with support from the Japanese government in 2000. Since then, new equipment was acquired by Unicef, the Esso and Chevron oil companies as part of projects covering specific areas. Since 2010, several municipal governments have procured cold chain equipment recommended by WHO/Unicef, but in small quantities, due primarily to the high prices of local vendors. In order to introduce new vaccines in 2013 and 2014, Gavi offered the country funds that were used for, among other activities, covering a portion of the cold chain deficit for provincial and municipal warehouses.*  *The 2015-2017 Gavi Graduation Plan allocated specific funds for the preparation of vaccine management manuals, and the maintenance and repair of cold chain equipment. The procurement of equipment for continual temperature control and updating of cold chain inventory at all levels of the health system. The inventory is in process and it will be completed in February of 2016. It will be of great help in rationalising the provision of equipment to the health departments and municipal levels for vaccine redistribution.*   1. ***Insufficient educational communication and empowerment of mothers and guardians of infants.***   *Health personnel from health units, in particular those that perform immunisation activities, must be supplied with knowledge and skills for effective interpersonal communication that transfers knowledge to mothers and caregivers for children, giving them the authority to demand their rights and qualify the demand for services.*  *With resources from the Graduation Plan, training material will be developed for interpersonal communication, and the training of trainers will be planned. This project will seek to supplement what has already been done using training material prepared and concentrating on the training of trainers in 11 provinces of the HSS-Gavi not only at the level of provincial and municipal social mobilisation supervisors, but also for NGO technicians. The project is also intended to activate NGOs, grassroots social organisations and traditional authorities for the promotion of vaccines, in particular new vaccines and the recovery of dropped out children with community participation.*  *The national policy for promoting and supporting Health and Community Development Agents (ADECOS) is an opportunity to expand interpersonal educational communication regarding health and to mobilise the target communities of the project to promote their own health.*   1. ***Poor quality of data and insufficient analysis and use of information;***   *The improvement of MINSA’s institutional capacity to improve data quality, monitoring indicators and assessment of results is a concern on the part of MINSA that is clearly prioritised in the National Health Development Plan. This project focuses on closing gaps and is intended to institutionalise data quality control processes, local analysis and use of information to make decisions at all levels. In this respect, periodic meetings will be held for data analysis and monitoring indicators and activities of the program: 1) Monthly meetings of the central team including the 4 subcommittees: technical, logistics, social mobilisation and finance. Minutes from the meetings will be presented during ICC meetings. 2) Bi-monthly meetings at the provincial level with an organisation similar to that of the central level. The minutes will be shared with provincial and national authorities; 3) Semi-annual assessment meetings in provinces attended by municipal teams in order to identify problems, the nearest support needs, and to make adjustments to achieve goals. These meetings will be attended by local NGOs and perhaps by national supervisors or partners; 4) Supporting the performance of periodic municipal data analysis meetings and monitoring of activities and indicators every 2 months with the participation of personnel from health care facilities and community members*  *Training of provincial statisticians and the central team in computerised data management and performing a periodic data quality self-assessment (DQS) and the procurement of computer equipment are not considered in this project because they will be performed using Graduation Plan funds from Gavi and the HSS Global Fund Project.*   1. ***Limited management capacity at the central level***   *In order to support the establishment of MINSA sustainable evidence-based policies, support is planned for establishing and institutionalising the National Immunisation Technical Advisory Group (NITAG), as a supplement to a project also funded by the Gavi Graduation Plan which will provide specific technical support for NITAG members.*  *The HSS-Gavi also intends to improve the central management of MINSA for the correct implementation of the Gavi Graduation Plan and the Health System Strengthening Project, contracting consultants for the following areas: 1) Acquisition and distributions of vaccines (CECOMA) for 17 months as a supplement to the graduation plan; 2) Cold chain and logistics for 17 months to support the EPI and probably to replace the national MINSA supervisor who is in the process of retiring, also supplementing the international support provided in the Gavi Graduation Plan 3) Health economist hired for 3 months of a health economist [sic] to support the National Public Health Directorate and the MINSA Secretary General in developing sustainable immunisation financing strategies and mechanisms for monitoring budget performance and payment of the Gavi co-financing.* |
| ***Pooled fund*** *applicants are not required to complete this question.* |

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| 12. Objectives of the NHSP and application *(Maximum 2 pages)* | | |
| *Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in* ***Attachment #6*** *- Detailed work plan, budget and gap analysis.*  ***Pooled fund*** *applicants are not required to prepare separate objectives, rather to list the key objectives from the NHSP, including ones relevant to immunisation.* | | |
| **Objectives** | **Description** |
| **Objective 1** | *Expand the offering of quality immunisation services in targeted 11 provinces and 97 municipalities.* | |
| **Objective 2** | *Expand the cold chain network, increase vaccine storage capacity and improve equipment maintenance, logistics and vaccine management at all levels.* | |
| **Objective 3** | *Strengthen interpersonal educational communication with regard to health in order to empower mothers and persons caring for children, focusing on immunisation.* | |
| **Objective 4** | *Improve MINSA’s capacity to institutionalise the periodic analysis and use of information, monitor activities and indicators at all levels of the health system.* | |
| **Objective 5** | *Strengthen national capacities to manage and define sustainable evidence-based policies.* | |

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| 13. Description of activities *(Maximum 3 pages)* | |
| *Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in* ***Attachment #6*** *- Detailed budget, gap analysis and work plan.*  ***Pooled fund*** *applicants are not required to complete this table, but should provide relevant sub-sections of the NHSP focusing on immunisation, including the annual work plan, activities and budget****; Attachment #34:*** *Pooled Fund Annual Work plan and Budget (AWPB****)*** *and related Terms of Reference* | |
| **Objective / Activity** | **Explanation of link to improving immunisation outcomes** |
| **Objective 1:** *Expand the offering of quality immunisation services in the targeted 11 provinces and 97 municipalities.* | |
| *Activity 1.1: Hold an introductory workshop for the Health System Strengthening Project for the MINSA central team and the 11 provincial teams.* | *The MINSA central team, provincial teams and partners know the contents, activities, schedule and results provided by the project.* |
| *Activity 1.2: Support MINSA in regulating and controlling funds for primary health care to ensure immunisation activities of advanced and mobile teams in communities without health care facilities* | *Increase geographic equity in access to routine immunisation by means of advanced and mobile teams in communities without health care facilities* |
| *Activity 1.2: Train 97 trainers (municipal EPI supervisors) in 8 "Immunisation in Practice" modules* | *Achieve the critical mass of trainers to train the personnel responsible for immunisation in health units* |
| *Activity 1.3: Train 1950 health technicians from 650 health units in 8 "Immunisation in Practice" modules (at least 2 technicians per health unit)* | *Improve micro-planning and the quality of immunisation care* |
| *Activity 1.4: Supervise technicians from 11 target provinces by the central EPI team (1 supervision every six months per province)* | *Improve the performance of provincial health teams* |
| *Activity 1.5: Supervise technicians from 97 municipalities by the provincial teams (1 quarterly supervision per municipality)* | *Improve the performance of municipal teams and health units* |
| *Activity 1.5: Purchase 11 vehicles to support training supervision and provincial logistics* | *Improve the frequency and regularity of EPI supervision and timely delivery of vaccines and material to the municipalities* |
| *Activity 1.6: Purchase 30 motorcycles to support difficult-to-access municipalities* | *Conditions to improve access to neglected populations.* |
| **Objective 2:** *Expand the cold chain network, increase vaccine storage capacity and improve equipment maintenance, logistics and vaccine management at all levels* | |
| *Activity 2.1: Train logisticians in 11 provinces in vaccine management, installation, preventive maintenance and repair of cold chain equipment.* | *Improve vaccine management and continuous functionality of provincial cold chain equipment* |
| *Activity 2.2: Train 97 municipal logisticians in vaccine management, installation, preventive maintenance and repair of cold chain equipment.* | *Improve vaccine management and continuous functionality of municipal and health unit cold chain equipment.* |
| *Activity 2.3: Purchase 180 TCW 40 SDD solar-powered cooler chests to expand routine immunisation in health units* | *Expansion of the network of permanent immunisation outposts.* |
| *Activity 2.4: Purchase 38 TCW 2000 SDD and TCW 3000 SDD solar-powered cooler chests to expand storage capacity at municipal levels* | *Expand the vaccine storage capacity at the municipal redistribution level* |
| *Activity 2.5: Transport and install 220 cooler chests and distribute 390 vaccine carriers from Luanda to the municipalities and health units* | *Ensure the availability of equipment in planned locations* |
| *Activity 2.6: Purchase 1 cold room with a net vaccine storage capacity of 30 m3 and an electrical power generator for the province of Huila* | *Conservation of appropriate quantities of vaccines at the Huila provincial redistribution level* |
| **Objective 3:** *Strengthen interpersonal educational communication with regard to health in order to empower mothers and persons caring for children with a focus on immunisation* | |
| *Activity 3.1: Train 25 provincial health promotion trainers and NGO partners in interpersonal educational communication techniques with regard to health, focusing on immunisation* | *National capacity to expand interpersonal communication knowledge and techniques related to health in municipalities* |
| *Activity 3.2: Train 130 health promotion trainers and NGO partners in interpersonal educational communication techniques with regard to health, with an emphasis on immunisation.* | *Local capacity to expand interpersonal communication knowledge and techniques related to the network of health services and community agents* |
| *Activity 3.3: Train 2600 health technicians of 650 health units in interpersonal educational communication techniques with regard to health, with an emphasis on immunisation* | *Provide mothers and persons caring for children with knowledge to complete the immunisation schedule on time and reduce the dropout rate* |
| *Activity 3.4: Perform activities for immunisation promotion and recovery of non-immunised children in communities* | *Increase in immunisation demand. Decrease in immunisation dropout rate.* |
| *Activity 3.5: Conduct qualitative research to assess the “impact” and adjust educational activities. (last quarter of 2017)* | *Assess the impact and obtain lessons learned* |
| **Objective 4***: Improve MINSA’s capacity to institutionalise the periodic analysis and use of information, monitoring activities and indicators at all levels of the health system.* | |
| *Activity 4.1: Hold, at the central level, monthly technical meetings for performance indicator data analysis and monthly monitoring of activities with the participation of the technical, logistics, communications and social mobilisation and finance subcommittees.* | *Strengthen the institutional capacity to manage and control data quality, identify problems and make decisions* |
| *Activity 4.2: Purchase 1 photocopier, 12 data shows for projecting presentations (central and provincial level) and server and network for the central database* | *Facilitate document printing for feedback and presentations. Provide the central database with an appropriate server and network* |
| *Activity 4.3: Hold, at the level of the 11 provinces, technical meetings every 2 months to analyse the EPI information, monitoring program activities and the accounting situation.* | *Strengthen the provincial capacity to manage data, monitor indicators and identify problems together with supervision data* |
| *Activity 4.4: Hold semi-annual provincial meetings to assess activities and performance indicators in the 11 target provinces, with the participation of technicians from 97 municipalities and local NGOs.* | *Identify local problems that prevent immunisation coverage from being increased, particularly in critical municipalities, make support decisions and adjust the implementation of activities.* |
| *Activity 4.5: Hold municipal meetings every 2 months to analyse information and monitor activities in the 97 target municipalities with the participation of health units and community representatives.* | *Review immunisation data quality, monitor coverage, analyse local problems, make decisions.* |
| *Activity 4.6: Final project assessment meeting with the central team and the provinces* | *Assess the project results in terms of the EPI, its contribution to institutional strengthening and obtain lessons learned* |
| ***Objective 5:*** *Strengthen national capacities for management and definition of sustainable evidence-based policies* | |
| *Activity 5.1: Activities and meetings of the National Immunisation Technical Advisory Group (NITAG) to support MINSA in defining policies and national strategies and independent monitoring of program progress* | *MINSA supported by an independent entity for defining sustainable evidence-based immunisation policies* |
| *Activity 5.2: Contract one economist for 4 months to support the National Public Health Directorate in cost and budget analysis, development of sustainable funding mechanisms including the monitoring of payment of Gavi co-funding* | *Support the National Public Health Directorate and the Immunisation Section to define funding options and effective management of resources.* |
| *Activity 5.3: Contract 1 national technician for technical assistance for CECOMA for 17 months in implementing efficient procurement, distribution and integrated management processes for vaccines and material* | *CECOMA personnel with increasing capacities to manage vaccine and materials purchasing and logistics processes* |
| *Activity 5.4: Contract 1 national cold chain technician for to provide technical support to the EPI for 17 months for training and supervising technicians in vaccine management and cold-chain at the sub-national level* | *EPI logistics personnel at the sub-national level trained in cold chain installation and maintenance* |

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| 14. Results chain *(Maximum 4 pages)* |
| *Complete the* ***Results Chain*** *using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.* |
| *Once the Results Chain has been developed, the next step is to complete the* ***Performance Framework*** *(for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal:* [*www.gavi.org*](http://www.gavi.org) |
| ***Pooled fund*** *applicants are not required to complete this template, but must provide a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP* |

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| **Chain of results (only for key activities)** | | | | | | |
| ***Objective 1:*** 🡺 *Expand the offering of quality immunisation services in 11 provinces and 97 municipalities in the country.* | | | | | | |
|  | **Key activities:**   * *Train 1950 health technicians from 650 health units in 8 "Immunisation in Practice” modules* * *Support MINSA in regulating and controlling funds for primary health care to ensure immunisation activities of advanced and mobile teams in communities without health care facilities* * *Supervise immunisation technicians from the 97 target municipalities on a quarterly basis by provincial EPI teams, giving priority to the municipalities with the least coverage.* |  | **Intermediate results:**   * *Increase the capacity of health care personnel in health units to expand the quality immunisation services offered* * *Increase geographic equity in access to routine immunisation by means of advanced and mobile teams* * *Improve the technical and organisational capacities of municipal EPI supervisors to increase the number of health units that offer immunisation services through permanent and advanced outposts* |  | **Immunisation products:**   * *Immunisation coverage for DTP-HepB-Hib3 > 87%.* * *Measles1 immunisation coverage > 90%.* * *> 70% of municipalities with DTP-HepB-Hib-3 coverage > 80%* * *Dropout rate for DTP-HepB-Hib1 / DTP-HepB-Hib3 < 15%* |  |
|  | **Indicators corresponding to key activities:**   * *Number of health unit technicians trained in the Immunisation in Practice package.* * *Number of municipalities that implement immunisation by advanced and mobile teams* * *Number of target municipalities supervised* * *Number of municipalities supervised at least 4 times a year* |  | **Intermediate Results Indicators:**   * *% of health units with at least 2 health technicians trained in the Immunisation in Practice package.* * *% of Municipalities that implement immunisation by advanced and mobile teams.* * *% of municipalities supervised at least 4 times a year* |  |  |
| ***Objective 2:*** 🡺 *Expand the cold chain network, increase vaccine storage capacity and improve equipment maintenance, vaccine logistics and management at all levels.* | | | | | |  |
|  | **Key activities:**   * *Procure 180 solar-powered (SDD) cooler chests to expand routine immunisation in health units.* * *Train logisticians in 11 provinces in vaccine management, installation, preventive maintenance and repairs for cold chain equipment.* |  | **Intermediate results:**   * *Expansion of the permanent immunisation outpost network (considering training personnel in Immunisation in Practice)* * *Improved effective vaccine management, continuous functionality and increased service life of cold chain equipment* |  | * *Immunisation coverage for DTP-HepB-Hib3 > 87%.* * *PCV-13 immunisation coverage >85%* * *Rota-2 immunisation coverage >85%* * *Measles1 immunisation coverage > 90%.* |  |
|  | **Indicators corresponding to key activities:**   * *Number of new health units with permanent immunisation outposts*      * *Number of provincial logisticians trained in vaccine management, installation, preventive maintenance and repair of cold chain equipment.* |  | **Intermediate Results Indicators:**   * *% of health units with permanent immunisation outposts* * *% of health units with permanent immunisation outposts* * *% of Provinces that submit a monthly SMT (Stock Management Tool) report in a timely manner* |  |  |
| ***Objective 3:*** 🡺 *Strengthen interpersonal educational communication with regard to health in order to empower mothers and persons caring for children, focusing on immunisation* | | | | | | |
|  | **Key activities:**   * *Train 2600 health technicians from 650 health units in interpersonal educational communication techniques with regard to health, with an emphasis on immunisation* |  | **Intermediate results:**   * *Increased enrolment of target population in immunisation for greater capacity of health technicians of health units to communicate more effectively regarding immunisation.* |  | **Immunisation products:**   * *Immunisation coverage for DTP-HepB-Hib3 > 87%.* * *Measles1 immunisation coverage > 90%.* * *Dropout rate for DTP-HepB-Hib1 / DTP-HepB-Hib3 < 14%* * *Dropout rate for PCV-1 to PCV-3 <14%* * *Dropout rate for Rota-1 to Rota-2 < 16%* |  |
|  | **Indicators corresponding to key activities:**   * *Number of health units with technicians trained in interpersonal educational communication* |  | **Intermediate Results Indicators:**   * *% of health units with at least 2 immunisation technicians trained in interpersonal educational communication techniques.* |  |  |  |
| ***Objective 4:*** 🡺*Improve MINSA’s institutional capacity to institutionalise periodic analysis and use of information, monitoring activities and indicators at all levels of the health system.* | | | | | |  |
|  | **Key activities:**   * *Hold municipal meetings every 2 months to analyse information and monitor activities in the 97 target municipalities with the participation of technicians from health units and community representatives.*      * *Hold semi-annual provincial meetings to assess activities and performance indicators in the 11 target provinces, with the participation of technicians from 97 municipalities and local NGOs.* |  | **Intermediate results:**   * *Specific problems regarding data quality and others that prevent immunisation coverage from being increased, acknowledged with the participation of the community and civil society organisations.* * *Assessment of progress, adjustments in prioritizing municipalities to concentrate support. Coordination and integration of funds with other programs and projects.* |  | **Immunisation products:**   * *Immunisation coverage for DTP-HepB-Hib3 > 87%.* * *Measles1 immunisation coverage > 90%.* * *Dropout rate for DTP-HepB-Hib1 / DTP-HepB-Hib3 < 14%* * *All supported municipalities have DTP3 immunisation coverage > 80%.* |  |
|  | **Indicators corresponding to key activities:**   * *Number of municipal meetings to analyse information and monitor activities with health units, technicians and community leaders (minutes available)* * *Number of provincial assessment meetings with municipal teams (minutes available).* |  | **Intermediate Results Indicators:**   * *% of municipalities that hold meetings to monitor immunisation indicators at least every two months* * *% of provinces that hold semi-annual assessment meetings* |  |  |  |
| ***Objective 5:*** 🡺 *Strengthen national capacities for management and definition of sustainable evidence-based immunisation policies.* | | | | | |  |
|  | **Key activities:**   * *Activities and meetings of the National Immunisation Technical Advisory Group (NITAG) to support MINSA in defining policies and national strategies and independent monitoring of program progress* |  | **Intermediate results:**   * *MINSA supported by an independent entity for defining sustainable evidence-based immunisation policies and external monitoring of program activities* |  | **Immunisation products:**   * *Immunisation coverage for DTP-HepB-Hib3 > 87%.* * *Measles1 immunisation coverage > 90%.* * *Dropout rate for DTP-HepB-Hib1 / DTP-HepB-Hib3 < 14%* * *All supported municipalities have DTP3 immunisation coverage > 80%.* |  |
|  | **Indicators corresponding to key activities:**   * *Number of NITAG meetings held* |  | **Intermediate Results Indicators:**   * *% of quarterly NITAG meetings held* |  |  |  |
| ***IMPACT***  *Provide an impact statement and indicator (s)*:  *A period of 18 months is not sufficient to achieve measurable impact indicators, however it is assumed that the cohorts of children and women protected with complete immunisation doses will contribute to a reduction in morbidity and mortality in the community, and given that the project covers nearly 60% of the population there will be a national impact.*  *The greatest contribution of the project is to control several conditions for sustainability of the increase in coverage and improvement in the quality of treatment, motivating and helping to articulate the management levels of the national health care system as a whole.* | | | | | | |
| ***ASSUMPTIONS***   * *The political leadership commitment and engagement that the Angolan President, the Provincial Governors and Municipal Governments have demonstrated throughout the years, with regard to immunisations, will allow the country to make major advances in the prevention and elimination of diseases. This strength that the country has, must be maintained in order to continue to make progress, since the benefit of immunisations and in particular the introduction of new vaccines needs to be consolidated in order to effectively and sustainably reduce the burden of diseases such as diarrhea and pneumonia, which rank second and third nationwide as causes of mortality for children less than 5 years of age.* * *The funding of all vaccines on the national immunisation calendar must increase in function of the increase in the population, and primarily taking into consideration the obligations of the Government to assume the entire cost of the new Pneumo13 and Rotavirus vaccines in the next 2 years.* * *The Gavi support fund for Angola Health System Strengthening (AHSS) which allows improvement in the coverage, equity and quality of immunisations, should be available in useful time at each level that has actions to be taken, in particular at the local level, so that the flow of procurement, distribution of materials and use of funds is fluid.* * *Contracts for technical personnel to support MINSA must be executed on a flexible and timely basis so as not to compromise the completion of project activities.* * *The implementation partners must provide effective support to MINSA for implementation of activities, in particular in the first year of the project, given the concentration of activities at various levels. The hiring of temporary technicians at the right time will be critical in order to provide effective support to MINSA.* * *The receipt, processing and payment of customs fees as well as distribution arrangements and the local assembly of equipment should warrant inter-detailed institutional plans with specific supervisors and budgets provided in a timely manner.* * *The activities and resources of the AHSS Project must be coordinated with other similar projects and financing for the EPI (funds from the Gavi Graduation Plan, new vaccine introduction grant and funds from other agencies) so as to avoid duplication, and the provinces not covered by the AHSS Plan should benefit from funds from the graduation plan in order to reduce inequities in support.* | | | | | | |

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| 15. Monitoring and Evaluation (M&E) *(Maximum 2 pages)* |
| ***Provide a description of how HSS grant performance will be monitored.***  *The project will be monitored based on the table of performance indicators, coverage and the process defined in this document. Monitoring shall be carried out at the three levels of the health system:*   * *At the central level, under the coordination of the National Director of Public Health, the Technical Subcommittee, the Social Mobilisation Subcommittee, the Logistics Subcommittee and the Finance Subcommittee will meet monthly to monitor compliance by activities. make adjustments, and submit problems and support requirements to the ICC.* * *During the monthly meetings of the ICC which are chaired by the Minister of Health and that include representatives of MINSA's technical and development partners and the agencies, a permanent agenda point will be the status of the Project for Health System Strengthening – Gavi. At these meetings, technicians shall present the status of the EPI performance indicators, broken down by provinces, as well as issues to be resolved.* * *At the provincial level, the Provincial Health Council will conduct a simplified monthly analysis in accordance with the central guideline of performance indicators, strengths, bottlenecks and support requirements for the central level. The provincial level will also be organised into 4 committees, like the central level. Every 6 months, assessment meetings shall be held with the municipal health directors and including local NGOs. The results will be sent to the central level for information and support.* * *At the municipal level, supervisors of the health care facilities will meet at the municipal seat every 2 months to review the performance indicators, problems and solutions. Members of grass-roots social organisations and local NGOs shall be invited.*   *The monitoring of the process and interim results shall be carried out based upon the established indicators (see annex).*  *For final assessment of the HSS-Gavi project, provincial meetings are planned with the municipalities, as well as a national meeting with provinces and immunisation coverage surveys by funded province in the graduation plan for the end of 2017. Qualitative investigations by the communication and mobilisation team carried out in the last quarter of 2017 will supplement quantitative data. The results of meetings of the central level subcommittees and the minutes of semi-annual meetings of the provinces and bimonthly meetings of the municipalities shall be useful. The Gavi performance indicators shall be used.* |

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

# Part D: Work plan, budget and gap analysis

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| 17. Detailed workplan, budget narrative and gap analysis *(Maximum 3 pages)* |
| *Complete* ***Mandatory Attachment #6: Detailed work plan, budget and gap analysis,*** *which can be accessed at the online country portal.*  *Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.* |
| *Once the budget template and financial gap analysis has been completed, provide a* ***budget and gap analysis narrative*** *here.*  *The total budget for the HSS-Gavi project for an 18-month period from 1 July 2016 to 31 December 2017 is USD 3,970,000. These funds were distributed among five components (objectives) that respond to the principal issues, which are:*   1. ***Expansion of quality immunisation services offered in the public health system****.- This will use USD 1,134,690 (29% of the total) for activities to develop health care personnel capacities at the municipal and provincial health unit level. Training events are planned in 8 Immunisation in Practice modules and per diems and vehicles to ensure training supervision that strengthens and consolidates knowledge and best practices. The planned per diem level was the equivalent of USD 125 for Luanda and USD 100 for travel to or from municipal and provincial posts, which is the standard amount that the WHO and UNICEF have used for several years, which is why it does not seem appropriate to modify it for inflation currently affecting the country since all payments are made in Kwanzas. For local participants, a subsidy of USD 15 was considered, which customarily allows the cost of meals to be covered during training (see detailed budget). The average cost for travel between Luanda and the provinces is USD 330 and travel from municipalities to provincial headquarters is USD 50. To support coverage expansion activities in 30 municipalities with difficult-to-access or nomadic populations, it is planned to purchase 30 motorcycles and the necessary spare parts and helmets to protect the technicians (see attached list of municipalities). It was planned to purchase 11 vehicles, which will make the work more dynamic and will improve supervision and logistics. The vehicles and motorcycles will be purchased by the WHO, which customarily performs this type of work. On the other hand, for implementing this component, consultants will be contracted on a short-term basis to regulate the use of decentralised primary care funds, translation of technical documents from English to Portuguese and review and technical simplification of the Immunisation in Practice package.* 2. ***Expansion of the cold chain network and cold chain storage capacity****,* ***and cold chain equipment maintenance****. This component will use most of the budget, which is USD 1,865,175 (i.e., 47% of the total). This component includes the purchase of 180 SDD solar-powered cooler chests to expand permanent immunisation outposts and 38 SDD cooler chests to increase municipal storage capacity, and also considers the purchase of a 30 m2 cold room with a generator for the populated province of Huila. The cooler chests will be purchased by UNICEF, including spare parts; the costs correspond to recent UNICEF quotations (see detailed budget and purchase and distribution plan). One of the most significant challenges of this component is transportation and installation, which will be made more difficult by the distance between municipalities and the rainy season. Transportation costs are high, calculated by taking into account the weight and volume of the equipment and local transportation costs. Development of logistics personnel capacities at the provincial and municipal level is prioritised because it will be critical for vaccine management, as well as for installation and maintenance of the equipment to be procured. The per diem parameters are the same for the entire project. Training activities will be concentrated in the 11 provinces and target municipalities and will supplement the graduation plan.* 3. ***Strengthening interpersonal educational communication in relation to health****.- This critical area that will contribute to social sustainability of the program is strongly supported in the Gavi Graduation Plan; in this project, actions are also focused on the targeted 11 provinces and 97 municipalities, USD 287,080 in funds were allocated, corresponding to 7% of the total. Funds were not considered for preparing and printing manuals and other promotional material because they are expected to be received from UNICEF. Funds for field training will be administered by the NGO CORE and its affiliated NGOs. The per diem levels for public health care and NGO personnel training events are the same as for other activities. The relative high cost of consulting for assessing the interpersonal educational component is explained by high logistics costs for travel to project areas.* 4. ***Improving data quality and use, monitoring and assessment****.- This component is also mostly financed by the Graduation Plan, especially the purchase of computer equipment for provincial and municipal levels and data management training, data quality self-assessment (DQS) training and others. These activities were not planned in the HSS-Gavi project in order to avoid duplication. This component is concentrated on data analysis and use at all levels of the system, giving high priority to the local level. The planned funds are supplemental to the Graduation Plan and amount to USD 393,099 (10% of the Project funds). In addition, servers will be purchased for the central database, to be connected to the central data platform of the Ministry of Health. A photocopier and 12 data shows will also be purchased for the central level and provinces supported.* 5. **Strengthening national capacities to manage and define sustainable evidence-based immunisation**.- The budget for this component is USD 92,200 *(2% of project funds)* and will supplement the support for establishing the Advisory Group (NITAG) by means of two activities, the first providing payment of USD 50 for participation by each member in official NITAG meetings (the same type of support as for members of the National Polio Eradication Expert Committee that meets monthly to consider critical aspects of the program). Furthermore, the Project plans to contract one economist for 3 months with a salary of USD 3,000 per month and 2 national consultants, one to support CECOMA in the vaccine purchasing process and another for cold chain and logistical support for the National EPI for 17 months, and the contracting processes should be completed in the first month of the project. The monthly salary of the latter consultants was set at a relative low amount of USD  1700 because there is the possibility of releasing them, particularly to the national EPI logistics, since the national supervisor is in the process of retiring and it will be necessary to hire another official. 6. *The amount of USD 197,755 USD, i.e. 5% of the project funds, was set aside to cover administrative expenses by the WHO and UNICEF. The proposed distribution of activities is similar to the graduation plan and considers activities for administration by UNICEF, such as purchasing cold chain equipment, communication and social mobilisation, contracting a cold chain technician and a CECOMA technician. The rest of the funds, including the purchase of vehicles, motorcycles and other equipment, would be administered by the WHO. The proposed table is attached hereto.*   *Of the USD 3,970,000 planned, USD 2,920,109 (74%) will be used in 2016 and the remaining USD 1,049,891 (26%) in 2017. This is because purchases of cold chain equipment vehicles should be made in 2016.*  *Considering the Gavi budget categories, the category with the greatest budget commitment is “Procurement & Supply Chain,” which will use USD 2,154,055 (54% of the total), followed by “Work Force and Human Resources,” with USD 861,900 (22% of the total), then the category “Health Information System,” which will use USD 372,899 (9%), “Community and Other Actions,” with a budget of USD 240,900 (6%) and others (9%).*  *Of the USD 3,772,245 available for activities, USD 252,430 (7%) will be managed by CSOs.*  *With regard to funds intended for the HSS-Gavi monitoring and assessment activities, USD 380,475 (9.6%) was budgeted. Furthermore, the 2015-2017 Gavi Graduation Plan includes USD 80,000 will allow immunisation coverage surveys to be conducted at the end of 2017.*  *The Gap Analysis shows the existence of funds from various sources that need to be integrated and harmonised in order to optimise their use and avoid duplication. Coordination opportunities are provided by ICC meetings to revitalise the Municipal Health System headed by MINSA and supported by the World Bank. The Government budget for these activities has not yet been approved as of the date of preparing this proposal.*  *Of a total budget of USD 36,164,718 from all sources related to the 5 HSS-Gavi project objectives, including the estimated Government budget, there is a deficit of USD 11,470,000.*  *The principal deficits correspond to the cold chain, for 8.1 million (which may increase with information from the ongoing inventory) and coverage expansion activities for 2.3 million (see attached Gavi Excel file).*  ***Support to expand coverage (HSS Gavi Objective 2)***   * ***The World Bank,*** *through the project to revitalise the Municipal Health System, will contribute USD˜10,650.00 for 2016, of which approximately 40% in the HSS-Gavi project area.*   ***Support for logistics and cold chain******(HSS Gavi Objective 2)***   * ***The Global Fund*** *has planned support to implement the logistics computer system and additional training for technicians for an amount of USD 523,082 for the period from July 2016 to December 2017.* * ***USAID*** *supported training for CECOMA technicians and assessment of the logistics system within the context of essential drugs through the Força Saúde NGO.* * *CECOMA has supported the construction of regional storage facilities in* ***Luanda, Benguela, Malanje****, based upon easy access through ports of entry and transportation to reduce distribution costs with government funds, the amounts of which are not available.*   ***Support for community agents (HSS Gavi Objective 3)***   * *National ADECOS [Health and Community Development Agents] Policy of the* ***Ministry of Territorial Administration and the Ministry of Health*** * *ADECOS consists of community agents who work in an* ***integrated*** *manner in health, education, agriculture, the environment and other areas.* * *Training of ADECOS agents funded by the* ***World Bank****, and their community work must focus on determining health factors, with funding to be supported by MAT. The amount planned for 2016 is USD 1,560,000* * ***Global Fund*** *financing will provide for ADECOS activities associated with health promotion, the amount of which is USD 3,037,304 for the period from July 2016 – December 2017.* * *UNICEF has committed USD 257,000 in the graduation plan, especially for 4 provinces.*   ***Support for the Information System (HSS Gavi Objective 4)***   * ***GEPE*** *[Office of Research, Planning and Statistics] is the agency appointed by the Ministry of Health in the INE for the information system; it will receive support from the* ***European Union*** *(PASS II project) to develop a national integrated information platform with special support for the Province of Benguela. The amount for the next 2 years is USD 3,500,000.* * ***WHO*** *is supporting development of epidemiological oversight in all provinces with technical personnel. 4 [million]* * ***USAID,*** *through the Força Saúde project, is supporting NHDP monitoring and assessment, which is currently underway. The amount was not determined.* * ***World Bank,*** *through the Municipalisation Project for Cuban Physician Health Support Services, contributing to the development and operation of information at the local level. The funds programmed for monitoring activities amount to 418,971 for 2016.*   *The geographic location of the support is illustrated below:*  [map]  *Note: The provinces of Luanda Sul and Moxico receive support with funds from the Gavi Graduation Plan.*  [map] |
| ***Pooled fund*** *applicants are not required to complete the workplan, budget and gap analysis template. Instead, specific information on the sector wide annual workplan and budget should be provided.* |

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| 18. Sustainability *(Maximum 2 pages)* |
| ***Describe how the government is going to ensure financial and programmatic sustainability of the results achieved by the Gavi grant after its completion.***  *Since 2002 Angola has been developing mechanisms to gradually reduce external dependence in health-related areas, and in particular for the Expanded Programme for Immunisation. So in 2004, the country launched a gradual process for funding traditional vaccines through the General State Budget, since to that point vaccines were funded nearly in their entirety by Unicef; the process was completed in 2007, when 100% of traditional vaccines and immunisation supplies were being funded by the Angolan Government, a situation which continues to this day. National immunisation campaigns, in particular for Poliomyelitis and Measles, require a great effort on the part of the Country, and since 2010, operating costs were covered in full by the State, and since 2013, vaccines for the campaigns have also been financed by the Government.*  *The current budget for the Ministry of Health has two specific budget lines for financing EPI activities under central authority. One of them is for co-funding of new vaccines and the other is for the procurement of traditional vaccines and operational activities at the central level. In the event that additional needs arise (as in the case of emergency immunisation campaigns), other budget line items may be used.*  *With regard to the operating budget that allows the performance of field activities, there are funds disbursed by MINSA directly to the Municipal Governments to cover the operating expenses for Primary Health Care. They were initially a pilot group of 68 municipalities and later all the municipalities in the country. With regard to immunisations, these funds are being used primarily for immunisation campaigns, travel by advanced and mobile teams, the procurement and maintenance of cold chain equipment, motorcycles and other materials and equipment. Notwithstanding the existence of funds in the municipalities, aspects related to the efficient use of funds disbursed to the municipalities, which can amount to up to 60% of the MINSA budget, must still be resolved. This project is intended to contribute to the effective regulation of the use of these funds and the establishment of control mechanisms. In addition, by eliminating the transmission of the wild polio virus in 2011, and the gradual reduction of multiple campaigns that previously numbered 8 per year, funds will be released to strengthen routine activities.*  *The evolution of the national budget for the EPI shows a clear increase from 21.9 to 47.3 million dollars from 2011 to 2014. In general, no central funding issues arise, except for the delayed payment of co-funding for new vaccines with Gavi. The absence of timely payment from Gavi was not due to a lack of budgeting, but primarily to the monthly division of the amounts to be transferred and the regulations and bureaucratic processing involving several Government entities that greatly extended the process for receiving and transferring foreign currency funding from Unicef Copenhagen. These situations have led to the accumulation of debt in excess of the specified budgeted amounts. In 2015, the Government made a significant effort to pay cumulative debts, creating a favourable situation for covering future costs.*  *With regard to the salaries of consultants for CECOMA and the cold chain to support the EPI, there is the possibility of absorption by the system, particularly for the cold chain and logistics technician. There are no continuity problems regarding per diems for the central level since national and WHO funds exist to support them. Continuity of per diems at the provincial level must be part of the negotiations with provincial authorities to increase the share of participation in regular financing for the municipalities.*  *The sustainability of the EPI also has to do with technological aspects covered by this project, such as the gradual conversion from gas-powered cold chain equipment to standardise solar equipment (SDD) approved by WHO/Unicef, which are more sustainable, easy to maintain, and have greater storage capacity, which facilitates their use particularly in rural areas and urban areas that experience frequent electrical power disruptions. The improvement of capacities of the provincial and municipal logisticians for effective vaccine management, preventive maintenance and the repair of cold chain equipment is an important part of the proposal. In addition, the procurement of spare parts for the procured equipment, so as to extend their service life.*  *The sustainability of programs is assured given the fact that the Health System Strengthening-Gavi is part of the 2016-2020 EPI Multiyear Plan and the 2012-2025 Health Development Plan, and there are no activities outside of these plans, which means that the activities will have continuity in function of the availability of funds in the country and the contributions of partners.* |

# Part E: Implementation arrangements and risk mitigation

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| 19. Implementation arrangements *(Maximum 2 pages)* |
| *The* ***general coordination*** *of the use of resources from the Health System Strengthening-Gavi (HSS-Gavi) and its integration with funds from the Government and other outside sources is carried out by the Interagency Coordinating Committee, which is chaired by His Excellency the Minister of Health and which includes participation by representatives and technicians from MINSA and implementation partners: WHO, Unicef, USAID, CORE Group, the Angola Red Cross, Rotary International, the Society of Pediatrics and the Project for Strengthening Municipal Health Services from World Bank. The ICC approves plans, monitors implementation of the same and facilitates the integration of resources and problem solving.*  ***At the central level, the primary implementation entities*** *of the HSS-Gavi will be: The National Public Health Directorate of the Ministry of Health (NPHD), through the Immunisation Section and the Health Promotion Department and the Office of Research, Projects and Statistics of the Ministry of Health (GEPE), through the Department of Statistics, in coordination with the NPHD and the EPI.*  ***At the level of civil society,*** *the NGO the Core Group comprising the NGOs supported by USAID and the Bill and Melinda Gates Foundation (AFRICARE, CRS, WORLD VISION, CARITAS e ASODER) will implement the information, education and communication (IEC) activities in accordance with the guidelines of the MINSA Health Promotion Department, in coordination with the Angola Red Cross, Rotary International and technical support from Unicef.*  *In order to respond to the large volume of activities required by planning and implementation of the HSS-Gavi, at the central level* ***functional inter-institutional subcommittees*** *will be resurrected, which will allow the implementation of Immunisation Campaigns (1) Technical Subcommittee; (2) Logistics Subcommittee; (3) Social Mobilisation Subcommittee and the (4) Finance Subcommittee. These subcommittees will work within MINSA on the call for bids of the National Public Health Directorate or of the Immunisation Section Chief. The subcommittees will be comprised of technicians from the Primary Health Care programs, implementation partners and HSS-Gavi consultants and other invitees.*  ***At the decentralised level, secondary implementation entities*** *of the HSS-Gavi will be the Provincial Health Directorates (PHD) via the Provincial Public Health Departments. These entities will monitor the implementation of activities and the use of funds and assets of HSS-Gavi by the Municipal Health Directorate and the Health Care Facilities of the context of the project.*  *At the provincial level, the* ***Provincial Health Committees*** *will be resurrected and will also have an organisational structure similar to the central level committees, and they will include technicians and members of local organisations and institutions. These commissions will be chaired by the Provincial Director of Health or the Provincial Chief of Public Health. The existence of WHO focal points with technical and logistics capacity in all provinces of the Country will be a gain for the implementation of the HSS-Gavi.*  *The Project will support municipal health departments in holding meetings to analyse data and monitor results, which we believe will provide incentive to achieve better results and will lead to evidence-based management.*  *The* ***Managing Entity of the funds from*** *HSS-GAVI will be selected by agreement between Gavi and MINSA, and it may be MINSA, WHO or Unicef.* |

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| 20. Involvement of Civil Society Organisations (CSOs) *(Maximum 2 pages)* |
| *Describe how CSOs will be involved in the implementation of the HSS grant.*  ***CORE Group***  *The Angola CORE group includes NGOs funded by USAID and by the Bill and Melinda Gates Foundation; it is very involved in routine immunisation activities and epidemiological monitoring by MINSA. It regularly participates in ICC meetings and is part of the immunisations technical subcommittee. The CORE Group also contributes to the acknowledgment of immunisation problems by conducting qualitative surveys regarding the perception of women and barriers to the full use of services. NGOs related to the CORE Group conducted an immunisation survey by sampling in 18 provinces of the country in late 2013.*  *The NGOs brought together in the CORE Group are: AFRICARE, CRS, WORLD VISION, SALVATION ARMY and the national NGOs CARITAS and ASODER; are present in 9 of the 11 selected provinces, and they do not have direct activity in the provinces of Cunene and Namibe. In order to conduct project activities in the provinces not covered agreements will be entered into with the Angolan Red Cross, religious leaders and traditional authorities, so as to promote immunisations and catch up children with immunisation.*  ***Angola Red Cross (CVA)***  *The Angola Red Cross is a non-governmental volunteer organisation that has active members in all provinces, that have participated regularly in the promotion and implementation of the multiple immunisation campaigns conducted in the Country. The Angola Red Cross is part of the Interagency Coordinating Committee of the Expanded Program for Immunisation. During 2011, 2012 and part of 2013 it administered funds donated by the oil company ESSO for immunisations, having supported operating expenses, the contribution of vehicles and cold chain equipment to MINSA.*  *The role of the Angola Red Cross will be to help in the field with implementation of community activities for promotion of routine immunisation and catching up children who were not immunised or those that started immunisation but did not complete immunisation specified in the National Immunisation Calendar.*  ***Council of Christian Churches***  *The Council of Christian Churches includes Catholic and protestant churches and is here to eventually participate in the immunisation social mobilisation subcommittee. Christian churches play a preponderant role in the promotion and implementation of immunisation activities at the community level during campaigns organised by the Ministry of Health. Religious leaders have demonstrated their openness to coordinating activities with the health care facilities and to carry out joint health promotion activities. This project intends to obtain support in the field for the systematic promotion of immunisation during religious ceremonies and extension activities to communities, in coordination with NGOs of the CORE Group and the Angola Red Cross.* |

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| 21. Risks and mitigation measures *(Maximum 2 pages)* | | | |
| *If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.*  *Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as ‘high’, please provide an explanation as to why it is ‘high’.* | | | |
| **Description of risk** | ***PROBABILITY***  ***(high, medium, low)*** | ***IMPACT***  ***(high, medium, low)*** | ***Mitigation Measures*** | |
| **Objective 1** | | | | |
| **Institutional Risks:** | *Med.* | *High* | *High-level advocacy with the Angolan Government (Gavi – WHO – Unicef) for timely payment of co-financing for new vaccines by MINSA and avoiding interruptions in inventory.* | |
| **Fiduciary Risks:** | *Low* | *Low* | *WHO and Unicef will administer the funds.*  *WHO focal points in the provinces accompanying the activities and actively recovering administrative allocations of funds made at the provincial and municipal levels.* | |
| **Operational Risks:** | *Low* | *Med.* | *In order to avoid interference of competitive activities during the intensive period of planned training, notify in advance and coordinate the scheduled training periods to the provinces.*  *MINSA must ask for quotations to rapidly begin the purchase of vehicles and avoid delays in acceptance.* | |
| **Programmatic and Performance Risks:** | *Med.* | *High* | *Municipal trainers (MLM course) training must be conducted in the first half of 2016 as part of the Graduation Plan already financed. A delay would postpone training health unit personnel in the immunisation package in practice* | |
| **Other Risks:** | *Med.* | *Med.* | *Delay in the release of procured vehicles from customs.*  *MINSA must allocate financial resources and have specific personnel for processing through customs.* | |
| **Overall Risk Rating for Objective 1** | *Med.* | *Med.* |  | |
| **Objective 2** | | | | |
| **Institutional Risks:** | *Low* | *Low* |  | |
| **Fiduciary Risks:** | *Low* | *Low* | *Unicef will procure cold chain equipment.* | |
| **Operational Risks:** | *High* | *High* | *Large volume of cold chain equipment to be transported and installed in a very short time period and the start of the rainy season.*  *Strengthening of the MINSA team involving the entire team from Unicef, World Bank, CORE and contracted consultants organised in the interagency logistics subcommittee.*  *Timely hiring of shippers for delivery of equipment and identification of personnel for local installation of solar and cold chain equipment.* | |
| **Programmatic and Performance Risks:** | *Med.* | *Med.* | *Timely hiring of technicians responsible for training for installation, maintenance and repair of solar equipment before arrival of the same.*  *It would be preferable for the solar equipment manufacturer to send consultants at no cost to support training the logistics personnel.* | |
| **Other Risks:** | *Med.* | *High* | *In order to avoid a delay in the release of purchase d cold chain equipment from customs, MINSA must allocate financial resources and have specific personnel for processing through customs.* | |
| **Overall Risk Rating for Objective 1** | *High* | *High* | *High priority for containing risks of this project component must be ensured.* | |
| ***Objective 3*** | | | | |
| **Institutional Risks:** | *Low* | *Low* |  | |
| **Fiduciary Risks:** | *Low* | *Low* | *NGOs in the CORE Group will conduct local monitoring jointly with the social mobilisation supervisors in the municipalities.* | |
| **Operational Risks:** | *Low* | *Low* |  | |
| **Programmatic and Performance Risks:** | *Low* | *Low* |  | |
| **Other Risks:** | *Low* | *Low* | *Insufficient coordination with supervisors of local implementation of the ADECOS initiative.*  *Coordinate in each municipality with ADECOS supervisors.* | |
| **Overall Risk Rating for Objective 3** | *Low* | *Low* |  | |
| ***Objective 4*** | | | | |
| **Institutional Risks:** | *Low* | *Low* |  | |
| **Fiduciary Risks:** | *Low* | *Low* | *WHO will administer the funds.* | |
| **Operational Risks:** | *Med.* | *Med.* | *Delay in providing accounting for operational level meetings may delay new funds from being delivered and interrupt activities.*  *WHO focal points in the provinces accompanying the activities and actively recovering administrative allocations of funds made at the provincial and municipal levels.* | |
| **Programmatic and Performance Risks:** | *Med.* | *Med.* | *The coordination and collaboration of the GEPE Statistics Department and the Immunisation Section of the National Directorate of Public Health must be ensured primarily for implementation of activities in the provinces.*  *Strict coordination with supervisors of the National Institutional Platform for information supported by the European Union.* | |
| **Other Risks:** | *No* | *No* |  | |
| **Overall Risk Rating for Objective 3** | *Med.* | *Med.* | *Improve internal and external coordination.* | |
| ***Objective 5*** | | | | |
| **Institutional Risks:** | *Low* | *Low* |  | |
| **Fiduciary Risks:** | *Low* | *Low* |  | |
| **Operational Risks:** | *Low* | *Low* |  | |
| **Programmatic and Performance Risks:** | *Med.* | *Med.* | *Insufficient qualification of selected personnel / delay in hiring.*  *Clear establishment of the reference terms and conditions and participation of partners on the selection committee.*  *Timely publication and quick selection of candidates.* | |
| **Other Risks:** | *No* | *No* |  | |
| **Overall Risk Rating for Objective 5** | *Low* | *Low* | *The selection of personnel for technical assistance must be given high priority.* | |

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| 22. Financial management and procurement arrangements |
| *The administrative entity that will manage the HSS-Gavi (WHO or Unicef) funds specified by a specific agreement with Gavi will be the party responsible for receiving the funds and delivering them through the NDPH to the units that implement the activities and Unicef for import procurement. This Administrative Entity will also be responsible for recovering the account reports and submitting the technical and financial report on the Project to Gavi.*  *At the level of the National Directorate of Public Health, the Administrative and Finance Unit will be strengthened with a national consultant qualified for financial management. This team, under the supervision of the National Director of Public Health will be responsible for managing the bank account opened specifically for external financial resources of the EPI.*  *The process of channelling Gavi cooperation funds will be as follows:*   1. *The WHO and Unicef Administrative Entity shall receive HSS-Gavi funds.* 2. *The Director of the National Directorate of Public Health shall request funds from the Administrative Entity, attaching the Quarterly Action Plan.* 3. *The Administrative Entity transfers the funds to a specific account maintained by the EPI with the National Directorate of Public Health-MINSA.* 4. *The Immunisation Section Chief of MINSA, the Health Promotion Department Chief of MINSA and the GEPE Statistics Department Chief request funds from the National Directorate of Public Health, attaching a detailed plan for implementation of activities.* 5. *The National Directorate of Public Health delivers the funds to the central level implementing entities, transfers funds to the implementing provinces and/or to the CORE Group in function of the approved plan.* 6. *The implementing entities shall submit the technical report on the activities carried out and original documentation of expenses incurred to the DNSP for review.* 7. *The DNSP will submit a summary of the technical and financial report for the funds received to the Administrative Entity. And they shall keep a file of all original disbursement documentation for future external auditing.* 8. *The administrative entity shall report to Gavi.*   *The process of the channelling of funds and administrative procedures for the procurement of equipment, vehicles, motorcycles or computers using funds from the Gavi Health System Strengthening Project will be as follows:*   1. *The Director of the DNSP requests procurement from Unicef, attaching the detailed plan of procurement including technical specifications for the products to be purchase d and the quantity and expected date of receipt.* 2. *Unicef sends the quote for the requested products and the estimated cost to DNSP.* 3. *DNSP confirms the procurement to be made in writing and requests the transfer of the respective funds from Unicef.* 4. *Unicef notifies in advance and delivers the products procured at the customs warehouses to the transporter of MINSA and the HSS-Gavi supervisors.* 5. *MINSA will retrieve the procured products from the customs warehouses and send them to the respective provinces after complying with the standards for contribution of the assets.* 6. *The EPI team, with the support of a cold chain and logistics consultant organises and supervises the installation of the cold chain equipment and the delivery of other assets to the implementing entities.* 7. *The implementing entities shall send DNSP the acceptance reports for the assets donated by HSS-Gavi.* 8. *The GEPE Director from MINSA or the Director of the DNSP shall inform the Administrative Entity.* 9. *The administrative entity shall report to Gavi.* |
| ***Describe the main constraints in the health sector’s budgetary and financial management system****.*  *The economy of Angola is based primarily on oil proceeds; in 2013, income from oil was estimated to account for 80% of the GDP. Throughout 2014 and 2015, the Angolan economy shrunk due to the dramatic decline in the international price of oil. The budget deficit expanded from 0.3% of GDP in 2013 to 33% in 2015. To survive the oil crisis, the Executive Branch is promoting diversification of the economy and the curtailment of costs.*  *The overall budget of the Ministry of Health (central level) for 2016 is 306 million dollars, which is 30-40% less than the previous year, according to information received. This budget is in the process of being approved, and it may still change.*  *The primary constraints are the decline in funds by the Ministry of Finance due to the financial crisis that the country is experiencing, which leads to the failure to carry out planned activities and the partial loss of effectiveness of the same. During the implementation of the funds received, the primary problem is complying with the budget line items allocated to expenses, as in the case of funds disbursed for primary health care to municipalities, and reviewing the submission of reports on the use of funds received.* |
| *Complete the* ***Budgetary and******Financial Management Arrangements Data Sheet*** *(below) for each organisation that will directly receive HSS grant finance from Gavi.* |
| *Provide* ***Mandatory Attachment #7****: Detailed two-year Procurement Plan* |
| ***Pooled fund*** *applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement* |

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| **Budgetary and Financial Management Arrangements Data Sheet** | | |
| **Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).** | | |
| 1. Name and contact information of Focal Point at the Finance Department of the recipient organisation. | Patrick Avognon Operation officer OMS  Mr. Niladri Bhattacharjee / Financial Specialist/Chief of Operations(OIC) UNICEF | |
| 1. Does the recipient organisation experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)? | YES | |
| 1. If YES:  * Please state the name of the grant, years and grant amount. * For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. * For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion). | * Introduction of polio inactivated vaccine grand (WHO 785,500 USD) * GAVI Graduation Plan Grant (WHO 608,325 USD, UNICEF 400,125 USD) both funds are ongoing in process.   The funds are requested by National Directorate of Public Health of MoH to WHO or UNICEF Representatives  The funds are transferred to specific bank account for EPI in MoH. The liquidations were collected by MoH and presented to WHO or UNICEF Representatives including technical and financial report. Was observed that the funds were utilised for planned activities, but was detected delay in liquidations. | |
| **Oversight, Planning and Budgeting** | | |
| 1. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process. | | NA |
| 1. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS? | | EPI and HSS officers with support of WHO, UNICEF and CORE Group |
| 1. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget? | | The minister of health during the ICC meetings with the participation of chiefs of agencies. |
| 1. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval? | | Yes |
| **Budget Execution (incl. treasury management and funds flow)** | | |
| 1. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request. | | Utilise the same bank used for other GAVI GRANTs  At the Ministry of Health level exist a specific bank account opened for GAVI Grants in 2003. Banco BFA, Account no. 728769/ Expanded Programme on Immunisation. Account in Dollars.  Three authorised signatures: 1) Minister of Health; 2) National Director of Public Health; 3) EPI Manager. For every release is necessary at least two signatures. |
| 1. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity? | | Commercial Bank: Banco de Fomento Angola (BFA) |
| 1. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- “pooled account”)? | | No. Is this account also transferred WHO and UNICEF for EPI activities. |
| 1. Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner. | | YES. The WHO or UNICEF will transfer funds to MoH central account by quarter. The MOH transfer the funds to provinces by activity according detailed plan. Provinces make the payments to districts. |
| **Procurement** | | |
| 1. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners’ procurement procedures) | | UNICEF (cold chain) and WHO (Cars, computers & motorcycles) |
| 1. Are all or certain items planned to be procured through the systems of Gavi’s in-country partners (UNICEF, WHO)? | | YES |
| 1. What is the staffing arrangement of the organisation in procurement? | | Supply officers of WHO and UNICEF |
| 1. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered? | | YES |
| 1. Is there a functioning complaint mechanism? Please provide a brief description. | | YES  The MoH inform by letter to WHO or UNICEF the identified problem, after the representatives meet with MoH authorities and solve the problem. |
| 1. Are efficient contractual dispute resolution procedures in place? Please provide a brief description. | | YES  Purchase agreement between MoH and Agency. |
| **Accounting and financial reporting (incl. fixed asset management)** | | |
| 1. What is the staffing arrangement of the organisation in accounting, and reporting? | | The administrative offices of WHO and UNICEF |
| 1. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?) | | WHO have GSM system and UNICEF have specific management system. |
| 1. How often does the implementing entity produce interim financial reports and to whom are those submitted? | | Monthly submitted to Regional Offices. |
| **Internal control and internal audit** | | |
| 1. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures? | | YES |
| 1. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS. | | YES  UN audit team |
| 1. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations? | | In each organisation the Representatives and Operation Officers follow up the accomplishment of internal audit recommendations. |
| **External audit** | | |
| 1. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[[1]](#footnote-2) | | Ministry of Health receive annual audits of “Economic Police”.  WHO and UNICEF Internal UN audits every 3 or 5 years. |
| 1. Who is responsible for the implementation of audit recommendations? | | The General Secretary of the MoH, and in the WHO or UNICEF the Representatives. |

1. If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget. [↑](#footnote-ref-2)