

**Health Systems Funding Platform (HSFP)**

**Health Systems Strengthening (HSS) Support**

**COMMON PROPOSAL FORM**

This common proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) Support from GAVI and/or the Global Fund.

**HSS Funding requests to the Global Fund using the Common Proposal Form and Guidelines can only be made when the application materials are launched on 15 August 2011**

This form is structured in three parts:

* Part A - Summary of Support Requested and Applicant Information
* Part B - Applicant Eligibility
* Part C - Proposal Details

All applicants are required to read and follow the accompanying guidelines in order to correctly fill out this form.

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| **Part A - Summary of Support Requested and Applicant Information** | | | | | |
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| **Applicant:** | | ***Ministry of Health, Solidarity, Social Cohesion and the Advancement of Gender Equality*** | | | |
| **Country:** | | ***Union of the Comoros*** | | | |
| **WHO region:** | | ***AFRO*** | | | |
| **Proposal title:** | | ***Funding for the Strengthening of the Healthcare System*** | | | |
| **Proposed start date:** | | ***July 2012*** | | | |
| **Duration of support requested:** | | ***3 years*** | | | |
| **Fund requested:** | | **Amount requested from GAVI:** | **1,799,265** | **Amount requested from Global Fund:** |  |
| **Currency:** |  | | |  | |

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| **Executive Summary**  *→ Please provide an executive summary of the proposal.* |
| ***TWO PAGES MAXIMUM***  The health situation in the Union of Comoros is characterized by high levels of maternal mortality (380/100,000 live births) and infant and child mortality (74 per 1000) with a major disease burden which is attributable to communicable diseases such as malaria, diarrheal diseases, HIV/AIDS; and non-communicable diseases including cardiovascular disease, diabetes and malnutrition. The precariousness of the health condition of the population is due to a number of factors, including the dysfunction of the health system of the country, which is caused by the lack of coordination and in the monitoring of activities, the aging facilities, the failure of drug procurement, inadequate management of human resources, the weakness of disease surveillance, the weakness of the health information system, the low level of research development, and insufficient financial resources.  The result of these conditions is the poor performance of the health system, an illustration of which can be seen in the difficulties encountered when attempting to maintain constant rates of immunization coverage at over 80% in the health districts, particularly in six (6) of them where the rate of immunization coverage is sometimes below 50%.  The document review has allowed us to identify the constraints of the health system which contribute to its poor performance. These are: (i) insufficient quantity and quality of human resources and their uneven distribution, (ii) the dysfunctions in the organization and coordination of health services, (iii) the outdated and inadequate state of the technical medical equipment, (iv) the frequent shortages of essential drugs, (v) the weakness of the health information system to gather data which may be used as a basis for decision making, as well as an underdevelopment of health research, the low funding given to health by the state, which leads to the low level of affordability of health in the face of the increasing impoverishment of the population, and (vii) the poor involvement of the population in the management of health services, with a lack of partnership between the public and private sectors.  This proposal was developed at the close of a participatory and inclusive process of the protagonists in the development in the health system in the country, under the authority of the National Health Committee. It falls within the goals and objectives of the 2010–2014 National Health Development Plan, namely (i) the reduction of morbidity and mortality which are related to communicable and non-communicable diseases, (ii) the reduction of maternal and child and infant mortality, and (iii) the improvement of the performance of the health system through the provision of good quality service.  More specifically, this proposal intends to: (i) make eight (8) District Health Centers and 23 Health Posts in those areas in which vaccine coverage is below the national average (which is currently 86%) functional and operational. Interventions will be based on the strengthening of capacities, including with regards to quality human resources and with regards to logistics in order to deliver the essential services packages in accordance with the standards defined for each level, (ii) to equip the management teams of the health districts in the targeted areas with the capacity and technical expertise in matters pertaining to the planning, organizing, monitoring and evaluating of the implementation of the programs or the development activities of the health districts, and (iii) to mobilize the population toward a greater use of the health services.  In accordance with the guidelines of the NHDP and the Comprehensive Multi-Year Plan (cMYP), the actions of the proposal will be based on 4 (four) strategic areas, namely: (i) the integration and decentralization of the actions, (ii) the strengthening of the technical and logistical capabilities, (iii) the strengthening of community participation, and (iv) the strengthening of the health information system. The implementation of the essential services packages through community outreach and out of the health posts and centers of the districts is the central implementation modality of these strategic directions. Particular emphasis will be placed on raising awareness and engaging the population in order to obtain their support in the implementation of the health activities.  To this end, 10 priority areas of service have been defined and include 29 actions that focus on the acquisition of the equipment and supplies which are primarily intended for the health posts of the districts; the organization of on-site training sessions of the health workers and community liaison personnel; the production and dissemination of various technical documents; the provision of support to the operational activities in fixed station and advanced station strategies in the 8 health districts. Support for the monitoring activities, support of the production of health statistics, and support for community involvement in the management of health services. This intervention should allow substantial progress to be made in the health coverage of the population, especially with regards to immunization coverage.  For greater efficiency of the GAVI financial support and based on the consensus-based criteria with regards to the rates of immunization coverage, the 8 health districts—that is, 8 district health centers and 23 health posts—were selected to receive support from GAVI/HSS. Thus the focus will be on the six (6) health districts which show the lowest immunization coverage rates, that is less than 70%, marked by a lack of coordination of the health actions, but which have functional structures with which to undertake the reforms which are necessary to achieve the goals that have been set.  The period covered by the requested support from GAVI for the strengthening of these eight (8) health districts is for a period of three (3) years, starting in the year 2012, for an amount which is evaluated at about six hundred thousand U.S. dollars (U.S. $600,000) per year; that is a total of about one million eight hundred thousand U.S. dollars (U.S. $1,800,000). The implementation of the proposal will be coordinated by the National Health Committee. |

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| **Part B - Applicant Eligibility** |

If this application includes a request to the Global Fund, please fill out the eligibility and other requirements section available [here](http://www.theglobalfund.org/en/application/materials/documents/#HSS).

If this application includes a request to GAVI, please click [here](http://www.gavialliance.org/support/apply/countries-eligible-for-support/) to verify the applicant’s eligibility for GAVI support.

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| **Part C - Proposal Details** |
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| **1. Process of developing the proposal** |
| * 1. **Process of developing the proposal**   *→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.* |
| The National Health Committee (NHC), created by Decree No. 07-092 / PR of May 31, 2007, is the supreme decision-making body in the field of health in the Union of Comoros.  In accordance with the abovementioned decree, the NHC is chaired by the Ministry of Health of the Union of Comoros. Its structure includes a National Technical Health Committee (NTHC), which is a technical body chaired by the Secretary General of the Ministry of Health of the Union of Comoros. The ministers in charge of the following sectors are members of the NHC: health, education, finances, civil service and environment of the Union of Comoros and the Commissioners responsible for the health of the Autonomous Islands; the representatives of the United Nations System Agencies, the President of the College of Doctors, Dentists and Pharmacists, representatives of the private sector and of the Ulemas (priests). The members of NTHC come from technical services of the departments and institutions which are members of the NHC. The National Health Committee is convened by its chairman in an ordinary session once a year and in an extraordinary session when necessary.  The mission of the National Health Committee is to:   * define national policies on matters pertaining to health development; * monitor the implementation of the National Health Policy; * ensure the effective involvement of all the parties involved in the policy development and implementation process, the health development plans and programs, and make all decisions toward the improvement of the health conditions of the population.   The process of the drawing up of the proposal has been coordinated by the Directorate General for Research, Planning and Health Statistics (DGRPHS) of the Ministry of Health, Technical Director in charge of the coordination and planning of the monitoring and of the evaluation of health actions.  The development of the process of developing the proposal, including the drafting of the document for submission was supported by the logistical and technical offices of the WHO and UNICEF. External technical assistance for 11 man-days was provided by WHO in this framework.  As a prelude to the development of the Comoros proposal, a workshop was held from November 22 to 25, 2011, under the aegis of the DGRPHS in order to take into account the comments made by the independent review committee of GAVI following the proposal submitted to GAVI in 2009. The document which was the result of the workshop was submitted to peer review during a workshop held in Harare from November 29 to December 2nd, 2011.Following this workshop, an editorial committee consisting of representatives of the central departments of the Ministry of Health, Civil Society organizations, and of the private sector which are involved in the health field, as well as the technical and financial partners (TFP), was established by Decree no.11-040/MSSCSPG/CAB. The committee held two meetings on February 4th and 5th, 2012, and this allowed them to establish the minutes of the workshop in Harare and a detailed timetable of activities which will enter into the framework of the elaboration of the proposal.  In accordance with the timetable established, a national workshop was organized from March 13 to 22, 2012, by the Ministry of Health with the support of technical and financial partners. The working sessions were used to analyze the needs, identify the gaps, and determine priority areas and the area of​intervention as well as the activities which relate to the National Development Plan (NHDP) and the Comprehensive Multi-Annual Plan (CMYP). A small drafting group was established to develop the document, taking into account the comments of the peer review.  The draft produced at the end of this workshop was reviewed by the National Technical Committee for Health (NTHC) on March 22, 2012. The observations made by the members of the NTHC were incorporated into the documents by the editorial board before the final document was submitted for approval by the NTHC. On March 23, 2012, the document approved by the NTHC was adopted by the NSC, the supreme coordinating and decision-making body of the health sector in the Union of Comoros. Following this adoption, the Minister of Health and the Minister of Finances signed the proposal before it was submitted to the GAVI Secretariat. |
| ***ONE PAGE MAXIMUM*** |
| 1.2 Summary of the decision-making process  *→ Please summarise how key decisions were reached for the proposal development.* |
| Throughout the development and validation process of the proposal, the decisions were made by consensus.  All the drafts of the proposal prepared by the working group were approved by the NTHC before they were submitted for approval by the CNS.  Following the rejection of the original proposal in 2009 by GAVI's Independent Review Committee (IRC), the technical group met from November 22 to 25, 2011, in order to review the proposal on the basis of the observations made. The draft which was the result of the meeting was subject to peer review during a workshop held in Harare from November 29 to December 2nd, 2011.  On February 4th and 5th, 2012, during a debriefing meeting, the mission team presented the comments and contributions of the peers to the whole writing team. A work plan was developed and validated by the technical group. It was recommended that a retreat be organized in order to include the peer observations to enhance the proposal with the assistance of an international consultant.  From March 13 to 22, 2012, a workshop was held in order to finalize the proposal. The document produced was validated by the National Technical Health Committee and subject to the approval of the National Health Committee.  On March 23, 2012, the National Health Committee met to approve the proposal. This meeting also brought together members of the IACC. Following the approval of the final document, it was signed by the Minister of Health and the Minister of Finances. |

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| **2. National Health System Context** |
| * 1. a) National Health Sector   *→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.*   * 1. b) National Health Strategy or Plan   *→ Please highlight the goals and objectives of the National Health Strategy or Plan.*  2.1 c) Health Systems Strengthening Policies and Strategies  *→ Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems, health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.)* |
| 1. **Epidemiological profile**   The epidemiological situation of the Union of the Comoros is dominated by malaria, diarrheal diseases (DD), intestinal parasites, acute respiratory infections (ARI). These conditions are the cause of significant morbidity and high mortality, especially among children under 5 years old and women. Low levels of supply and demand of quality services are the fundamental determinants of high rates of maternal (380 per 100,000 live births) and registered child and infant (74 in 1000) mortality rates recorded in the Union of Comoros. HIV/AIDS and other sexually transmitted infections are also a major concern despite their relatively low prevalence.  Moreover, according to the results of the "Step Wise" survey conducted in 2011, non-communicable diseases, including malnutrition, diabetes mellitus, cardiovascular disease and high blood pressure rose alarmingly. Despite the scarcity of data, cancer appears to be a public health problem.  **Maternal Health**  The indicators of maternal health are a cause for concern. Despite the relatively good rate of births which were attended by qualified personnel (80%), according to the 2009 survey on the elimination of neonatal tetanus, the maternal mortality rate remains high (380 per 100,000 live births according to the RGPH2003). The rate of births which are registered in hospitals is 51%. On average 40% of pregnant women who came for ANC1 did not return for ANC2; only the five hospitals (the NHC, and the 2 RHC and the 2 SMC) provide comprehensive emergency obstetric care. Among women, genital cancers are the leading cause of cancer-related mortality.  **Child Health**  The rate[[1]](#footnote-1) of neonatal mortality is 10%. Its main determinants are preterm birth (29%), fetal distress (21%), asphyxia (14%), and other unidentified causes (7%). As for the infant[[2]](#footnote-2) and child mortality rates, they are, respectively, 59 and 74 in 1000 and are mainly related to malaria, ARIs, malnutrition and diarrhea. The proportion[[3]](#footnote-3) of children who are underweight is 13.8%, those with stunted growth is 27.8%, and those with an energy deficiency is 6.4%.  The immunization[[4]](#footnote-4) coverage in 2011 for the different antigens was respectively 88% for BCG, 92.1% for DTC/Hep/Hib1, 86.7% for DTC/Hep/Hib3, 78% for measles and 22.8% for TT2+, whereas the GIVS (Global Immunization and Vaccine Strategy) recommends a rate of 90% for all antigens. Out of all of the health districts of the country, only 12 have a DTC/Hep/Hib3 coverage that is greater than or equal to 80%.The most disadvantaged island is that of Grande Comore where DTC/Hep/Hib3 coverage is only at 72%, with areas where immunization coverage is below 50%.  In terms of malnutrition, there is a lack of protein in the diets of pregnant and lactating women as well as in children under 5 years of age. According to the evaluation report on the nutritional status of children less than 5 years of age and mortality in the Union of Comoros, by UNICEF, December 2009, the prevalence of moderate acute malnutrition and severe acute malnutrition were respectively of 7.1% and of 1.6% in Anjouan, of 2.4% and 0.9% in Grande Comore, and 4% and 3% in Moheli. **Health system** The institutional framework of the health sector of the Union of Comoros is made up of structures at the central, regional, and district health levels.  ***At the central level*,** the structures of the Ministry of Health include the Minister's Office, the General Secretariat (including the Administration and Finance Directorate and the department in charge of Human Resources), the General Directorate for Research, Planning and Health Statistics, the General Inspectorate of Health and the National Directorate of Health (including the Directorate of Public and Private Health Institutions, the Directorate for the Fight against Disease, the Directorate for the Fight against AIDS, the Directorate of Family Health and the Directorate of Health Promotion) and the independent establishments of a public nature which are the National Autonomous Pharmacy of Comoros, and the National Hospital Center.  There are, also, national programs in place in order to fight against priority diseases. These are: The National Program for the Fight against Malaria, the National Program for the Fight against Tuberculosis and Leprosy, the National Program for the Fight against Blindness, the National Program against Filariasis, the Expanded Immunization Program, all attached to the Directorate of Fight against Illness.  At the level of coordinating bodies, there are:   * The National Health Committee, chaired by the Minister of Health, is the highest policy and decision-making body. * The National Technical Committee for Health, chaired by the Secretary General, is the technical body which is responsible for the monitoring and for the technical coordination of health programs. * The Inter-Agency Coordinating Committee, chaired by an elected member, is responsible for monitoring and for the coordination of immunization activities. * The National Committee for the Fight against AIDS, chaired by the President of the Republic, whose mission is to coordinate and direct interventions in the fight against AIDS. * The National Steering Committee of the Development of Health Human Resources.   ***At an island-wide or regional level****,* there is the Commissioner responsible for Health (SG, IGS and DAF) and the Regional Health Directorate (with program managers). Each region is organized in health clusters and each cluster includes one or more health districts. Each island is covered by a RHC (Regional Health Center) except the island of Ngazidja, where the coverage is provided by the NHC (National Health Center). The NHC and the RHC are under the direct supervision of the Ministry of Health of the Union of Comoros.  ***At the level of the health districts,*** each district is divided into health areas, and the local institutions are the District Health Centers (DHCs) and Health Posts (HP). At the district level, a DHC is designated as a referral hospital. Officially, the management of the DHCs is entrusted to management associations and they are administered by a board of directors and the technical health team of the district. As for the health posts, they belong to the community and are administered by the affected populations and the health team.  **Health facilities in 2012:**  The Union of Comoros has 1 NHC, 2 RHC, 2 SMC (Surgical Medical Centers), 3 UMC (Urban Medical Centers), 12 CSD (District Health Centers) and 52 HP in the public sector. Besides that, there are 1 MSC, 4 CARITAS health centers, and 15 practices and clinics in the private sector. As for the facilities, the priority issues identified are:   * The inability to meet established standards, as well as their dilapidated and underequipped condition which can be attributed to, among other things, the weak enforcement of the regulations in force and to the lack of investment and maintenance policies. * The uncontrolled implantation, due to noncompliance with the health map, which can be attributed to insufficient monitoring on the part of political and administrative authorities and to cross-communal rivalries. This problem is much worse in the private sector, where no implantation standards exist. * The low level of maintenance of the health facilities.   Geographical access to a structure which provides health within a 5 km radius is estimated at 45% on Grande Comore, 74% in Anjouan, and 69% on Moheli; that is a national average of 63%. The entire Comorian population has access to a structure which provides health within a 15 km radius. However, this accessibility is only theoretical due to the poor quality of the roads and the small number of health facilities which are operational because of lack of qualified staff, and this prevents the access of the general population to quality health services in several regions of the islands. The rate of use of health facilities is very low. The figures are at 14.7%, 20.21%, and 8.92% respectively in Grande Comore, Anjouan and Moheli, establishing a national average of 10.25%.  **The laboratory and pharmaceutical systems:**  The Union of Comoros has had a National Pharmaceutical Policy (NPP) since 2004. However, the implementation plan of this policy is still being developed.  Coordination of the pharmaceutical sector is provided by the Directorate of Public and Private Institutions within the National Health Directorate. The supply of essential drugs is the responsibility of the National Autonomous Pharmacy of the Comoros (PNAC).  The sale of drugs to the public is provided by 18 pharmacies, including 3 under the PNAC, 15 from the private sector, as well as 59 private stores. All health facilities have a drug sales depot which is supplied by the PNAC.  The National Health Center (NHC) and the Regional Hospital Centers (RHC) of the islands have laboratories and blood banks available to them.  The National Blood Transfusion Center, whose creation decree (Decree No. 01-130/CE of December 27, 2001) was passed, has not yet been established. The pharmaceutical industry is faced with:  Frequent breakdowns of stocks of medicines (56%);   * Weak regulation of the sector; * Irrational use of the medicines; * Doubtful quality of the medicines; * Weak promotion of traditional pharmacopoeia; * The poor technical capacity of the existing laboratories.   A restructuring of the PNAC is underway to improve the management of the medication in order to ensure continuous availability.  Human resources:  According to the 2011 census, the country has about 1361 health workers, including 912 health providers, among which are 137 doctors, 7 pharmacists, 15 pharmacy technicians, 370 state-certified nurses, and 225 state-certified midwives.  The Union of Comoros has a National Human Resource Development Plan (NHRDP) which covers the period of 2010–2014.  For basic training, the country has a National School of Health which is attached to the University of Comoros. At present, this school only trains middle-level health personnel (midwives and state nurses). Its yearly capacity is of 35 to 40 new students. Can be noted:   * The lack of qualified human resources mainly due to (1) the limitations of recruitment and the mismatch between existing budget positions and the professional staff, (2) the low capacity of the National School of Public Health, (3) the lack of training institutions for senior health managers (4) the brain drain; * The poor allocation of human resources, with a concentration of the latter in large urban centers, particularly because of (1) the lack of incentive to work in the periphery, * The low level of staff productivity, which is related to a lack of motivation, due in part to the lack of career planning, the inadequacy of the management framework, and the delays in paying salaries.   **Sanitary Information System (SIS)**  The body responsible for the SIS is the Directorate of Information and Health Statistics (DIHS), which falls under the Directorate General for Research, Planning and Health Statistics. At the central level, in terms of human resources, the DIHS is led by three people. At the island level, five people work on the SIS (3 in Njazidja, and 2 in Nzwani and Mwali). An evaluation of the SIS conducted in 2007 with support from the Health Metrics Network (HMN) identified the following priority issues:   * The inadequacy of the institutional framework of the SIS for better coordination, proper control and effective integration of the interventions. This problem is mainly due to low technical capacity of the structures responsible for the SIS, particularly in terms of technical skills and equipment; * The inadequacy of indicators, particularly in regard to the quality criteria, the comprehensiveness, the taking into account of the MDGs. For this purpose, the definition of the health indicators which were identified in the Master Plan of the SIS has not fully taken into account the needs of all partners and programs (lack of harmonization/integration of the indicators) because, inter alia, of the low intra-sectoral and inter-sectorial cooperation; * The non-availability and accessibility of reliable statistics because, inter alia, of the lack of motivation (reward/punishment) of those responsible for the SIS at different levels, the lack of monitoring and supervision in order to ensure the availability and quality of data, the complete absence of mechanisms to collect data from the national health system accounts, and the malfunction of the civil registry system. * The limited capacity for management of the data, which is linked to the lack of qualified human resources, and to the lack of a health information archiving system. * The low capacity of usage and of dissemination of the data, which is primarily linked to the failure in data presentation and to the poor coordination and collaboration of those involved.   A development plan for the SIS was subsequently developed and is currently being implemented.  **Knowledge and research and management**  Apart from the occasional isolated activities that are undertaken under the aegis of the development partners, research remains the poor relation of the health system in the Union of Comoros. The establishment of a National Research Committee during the evaluation of the research institutions which was conducted in 2008 did not develop as expected. However, with support from WHO, interventions are planned for training health workers in the field of operations research.  **Health financing:**  Given the strong budget constraints in the Union of Comoros, the share of public spending which was spent on health in the state budget went from 8.6% in 1998 to about 4% in 2008, a withdrawal on behalf of the state which is relatively disturbing. This part of the health budget in the state budget is well below the Abuja targets (by 15%).  In addition, the external financing of health is difficult to assess due to the poor coordination of external support. In the state budget, the PIP (Public Investment Plan) indicates that there is funding from some donors, but this list solely takes into account the support of UN agencies, of the Global Fund, and of a few projects which are funded by bilateral and multilateral cooperation (particularly French, Japanese, Chinese). Private donors (especially from the Gulf area), and the NGOs (related to the diaspora, for example) do not appear in these figures.  The very low level of external financing of health care in the overall external financing which the country has benefited from can also be noted. It rose from 6.7% in 2005 to 7.4% in 2006. The prospects which were projected for 2007 and 2008 remained at lower levels, that is, respectively 4.1% and 6.8%.  **Private sector and civil society**  The private sector is underdeveloped as well as poorly regulated. Despite that, it greatly contributes to the delivery of health care to the population. However, access remains limited to a small segment of the population due to the very low purchasing power.  Associations are barely developed in the Comoros. The only visible NGOs in the health sector are the ASCOBEF (Comorian Association for the Welfare of the Family), the Comoros Red Crescent Society (CRC), and CARITAS. These NGOs are involved preferentially in the fields of reproductive health and humanitarian emergencies.  At the level of professional associations, the College of Physicians, Pharmacists and Dentists, as well as the Midwives Association, are not working satisfactorily. As for midwives, initiatives are still limited to two islands and should be generalized.   * 1. **b) National Health Strategy or Plan**   In order to resolve the weaknesses of the health system, a National Health Development Plan has been developed covering the 2010–2014 period, which aims to ensure better health for all Comorians through the availability and accessibility of good-quality services. Reaching this goal will be achieved through the accomplishment of the following objectives: (i) the reduction of morbidity and mortality of communicable and non communicable diseases; (ii) The reduction of maternal and child and infant mortality; (iii) The improvement of the performance of the health system through the provision of good-quality service. These goals were then broken down into strategic areas of intervention.  **2.1 c) Health Systems Strengthening Policies and Strategies**  In accordance with the strategic directions of the NHDP (National Sanitary Development Plan), the improvement of the performance of the health system will be brought about through the provision of quality services by: (1) the strengthening of the institutions for better coordination and monitoring and evaluation of the programs; (2) the renovation and equipping of existing facilities and the building and equipping of new facilities; (3) hospital reform; (4) the strengthening of the pharmaceutical system, including the laboratories and blood transfusion safety; (5) the development of the human resources; (6) the strengthening of the health information system; (7) the promotion of research and the management of knowledge; and (8) the improvement of the affordability of health services and the increased funding of health programs. |
| ***FOUR PAGES MAXIMUM*** |
| 2.2 Key Health Systems Constraints  *→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).* |
| **The main constraints of the health sector are as follows:**   1. ***Lack of qualified staff in health posts and in district health centers.***   According to the health personnel census conducted in 2011, the ratio of medical staff (doctors, nurses and midwives) per 10,000 inhabitants is 7 caretakers for 10,000 inhabitants. This is less than the generally accepted level of 25 caretakers per 10,000 inhabitants, and puts the Union of Comoros among those countries facing an acute shortage of human resources.  To the detriment of the health districts, this staff is also poorly distributed among the various levels of the health pyramid. According to the rapid assessment of the health districts[[5]](#footnote-5), only 20% of DHCs had a full management team (1 doctor, 1 state nurse, 1 state midwife, 1 dentist, 1 laboratory technician and 1 manager). Of the 52 health posts in the Comoros, close to 40% work with unqualified personnel. Finally, this staff, whose skills with regards to management of district health services are very limited, lacks motivation to work properly mainly because of poor physical working conditions. Insufficient financial resources for the proper functioning of the health posts and district health centers. The share of the operating budget for health in the national budget was at about 4% in 2007 and 2008. The Finance Act of the Union of the Comoros provides no subsidy that would benefit the health districts. As for the budgets of the autonomous islands, according to the Finance Act of 2008 of the island of Ngazidja, the budget allocated to health represents 4.6% of the total budget of the island, and from this the portion which is intended for the health districts is 12.7%. Unfortunately, the rate of disbursement of these funds for the district health centers is ridiculous.  This leads the functioning of health services to be deeply dependent on outside financing and cost recovery (direct payment of care by the patients). The cost recovery method causes the costs of health services to be too high in relation to the purchasing power of the population, 44.8% of which lives below the poverty line. As a reference point, the costs of some services can be used to illustrate the situation: (i) the minimal cost of a caesarean section is 45,000 KMF (92 Euros), and is 1.4 times higher than the country's guaranteed minimum wage, the amount of which is fixed at 32,000 KMF (65 Euros); (ii) access to prenatal care is subject to the payment of the sum of 2,000 KMF (4 Euros), and the total cost of examinations for pregnancy care is estimated at about 25,000 KMF (51 Euros). These costs cause real financial barriers to accessing the care and services which are offered. They explain, at least in part, the low rates of the use of services in general, and of antenatal care, especially causing low immunization coverage of pregnant women. Low capacity for organization, implementation, monitoring, supervision, evaluation, and coordination of interventions in the health districts According to the results of the health district system rapid assessment report, the management of the health districts is generally flawed, despite the fact that 69% should have functional boards of directors (BoD). Indeed, when compared with established standards, health teams only carry out 23% of staff meetings, 23% of the monitoring, and 40% of supervision activities, and only 13% of the districts have annual work plans. As a result, the coordination and monitoring of programs, including EPI, are not effectively performed. Insufficient and inadequate facilities and technical equipment in the health posts and district health centers Weak and inadequate facilities and technical equipment in the health posts and the district health centers constitute an obstacle to the availability of quality care and services. For information, besides the lack of equipment for preventive consultations of children and antenatal visits, none of the 52 health posts offer immunization services due to a lack of equipment. This situation is compounded by the lack of maintenance systems, and the lack of allowances and of equipment replacement.   Frequent breakdown of stocks and irrational use of drugs The pharmaceutical sector faces several problems, including the lack of qualified human resources, the lack of a regulatory mechanism, and the lack of structure for the quality control of drugs. Indeed, 74.6% of pharmacies and dispensaries are operated by unqualified personnel. The result of this is an irrational use of medicines of uncertain quality, an insufficient estimate of the needs, a low use of the management tools, and numerous drug shortages observed in the health facilities. Largely dysfunctional health information system, characterized by a multiplicity of supports, the existence of parallel systems for collecting and managing data, and a low dissemination of the data. In general, the district health teams do not have the appropriate technical tools and technical skills which are sufficient for analysis and proper handling of the data. In addition, no feedback is given on the data they collect and transmit to the SMD (Systems Management Directorate) level. The evaluation shows that the amount of data processing and analyzing at the different levels is very limited. This explains their low capacity to produce information and statistical reports. Furthermore, there is a parallel system of data collection set up by some programs. Low involvement of the community, and low partnership with the private sector The low involvement of community liaison personnel and the weak collaboration between the health services and the NGOs for preventive health actions are in part impediments to the mobilization of the population in favor of immunization activities. Furthermore, the development of partnerships between the public and private sectors would allow the increase in availability and accessibility of health services.  ***TWO PAGES MAXIMUM*** |
| 2.3 Current HSS Efforts  *→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.* |
| **For the strengthening of the health system, efforts are being made at different levels in relation to:**  **Human resources:**  Efforts are underway to address the crucial issue of the lack of qualified staff in the health posts and district health centers through:   * the organization of continuous training schemes targeted according to the needs of specific programs * the recruitment by the island authorities of the SFE and IFE at the DHCs and HP levels * a training plan for staff nurses is in progress with the support of the PASCO project, * the organization of advanced training events for the improvement of staff skills in the framework of the regional cooperation projects. * the training of specialists * the establishment of technical assistants in the DHCs with the support of partners.   But all of these activities are still insufficient to remove this bottleneck.  **Financial resources**  In order to help reduce the effects which are caused by the lack of the financial resources which are required for the proper functioning of the health posts and district health centers:   * test involving the development of health care mutual organizations are underway, particularly in Anjouan; * The Union of Comoros will begin the development of national health accounts in order to capitalize all the cash flows and to better direct budget allocations; * within the framework of the PASCO project, the five hospitals (NHC, RHC and SMC) are subsidized according to a well-defined allocation formula. Some districts (1 SMC, 1 CSD) receive additional funding based on their level of performance in order to allow the poor access to health care.   **Equipments**  Substantial efforts are underway to remedy the shortage and inadequacy of the facilities and the technical equipment, particularly in the 5 hospitals, 7 District Health Centers, and 34 health posts, with the support of the following partners: Japanese Cooperation, AFD through the PASCO Project, Qatar, IDB, and the UN System Agencies. The renovation and re-equipment of the operating theaters, the allocation of ambulances to certain DHCs, the equipping of the HPs and the funding of the advanced strategies which allow the swift management of dystocia deliveries and the closer delivery of preventive and curative care to the populations. To this can be added the donation of two dialysis machines and of two blood banks. Despite these renovations and this equipment, empty health zones persist, and several health posts lack the equipment which would enable the performance of the package of preventive activities for the health of mother and child.  **Sanitary Information System**  The National Development Plan of the Health Information System (NDPHIS) which was developed in March 2009 following the evaluation recommends six strategic areas:   1. Design and implementation of an appropriate institutional framework; 2. Strengthening of the technical capacities in human and material resources of institutions in charge of the SIS; 3. Definition and harmonization of the health indicators which meet the monitoring and evaluation needs, and which meet the required technical criteria; 4. Integration of health information sub-systems and strengthening the links between the Ministry for Health and the other departments that produce information on health; 5. Mobilization of the financial resources which are necessary for the development of the SIS; 6. Continuous evaluation of the performance of the SIS.   In the implementation of the plan, strategic areas 2 and 3 were considered to be priorities and are in the process of being developed with the support of the PASCO Project. Thus, the staff in charge of the NHIS both at the central and island levels have received training, and the Directorate of Information and Health Statistics has been equipped with computer equipment (3 computers + 1 multifunction color printer) and furniture.  Indicators were defined and the normative framework of the SIS is being reviewed. After the test phase, performed on two islands, the generalization at the level of every district is in progress, but obstacles remain and these are hindering the development of the NHIS.  Epidemiological surveillance of diseases, including that of the EPI target diseases, is an early warning system for the Department of Health. This fight was reinforced by a "case by case" surveillance, which is developed as a complement to immunization. It is supported by the IOC project, which focuses on strengthening staff skills and computer equipment for fever surveillance. Therefore, it is important to develop an integrated surveillance system for diseases.  **The organization of health services:**  Under the new health map of 2009 and in order to have more efficiency, the health districts were grouped into health clusters. Thus, the Union of Comoros has been divided into 3 health regions and 7 health clusters. Each cluster comprises one or more districts. A health center will be designated in each district level as a referral hospital which will be provided with support and referral for all health activities. A family health center for the cluster will be designated as a health clinic in which all the preventive and promotional actions for the health of mother and child will be carried out. But this reorganization has yet to be operational. The functionality standards are defined for each health facility within the district and the tasks of each district management team are described in order to facilitate evaluation. Each district is being equipped with an annual action plan that will meet its specific needs. A monitoring plan must be appended to the plan of action. The leadership of the district management teams will need to be strengthened.  ***THREE PAGES MAXIMUM*** |
| **3. Health Systems Strengthening Objectives** |
| * 1. HSS objectives addressed in this proposal   *→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.* |
| ***Goals and objectives of the support to the HSS by GAVI*** The implementation of the proposal submitted to GAVI for the health system reinforcement aims to contribute to the reduction of maternal and child and infant morbidity and mortality by improving the performance of the health districts of the Union of Comoros.  Reaching this goal will be achieved through the development of the following objectives:  Objectives:   1. **Improve the organization and coordination of health services, including the immunization programs at every level of the health system by 2014**   The weak management capacity of the health services has a negative influence on the supply of curative and preventive care, and this includes immunization. A better organization of the national health system and the improvement of the contribution of the community and the private sector are recommended in the solutions offered in the 2010–2014 NDPH. In order to achieve this goal, the operational level of the health districts must be strengthened, as well as the planning and inter-sectorial collaboration process, the coordination of interventions in the health sector while taking gender issues into account when implementing the health programs.  GAVI's backing is requested to support the development of this reform.   1. **Improve the rate of district health attendance from 19% to 30%, especially for women and children under 5 years of age in targeted areas by 2014, in accordance with the established standards.**   Three points will be developed in order to achieve this goal:   1. ***Strengthen the infrastructure, equipment, and the maintenance in the less-favored areas by the end of 2014***   Despite the relatively good theoretical coverage of the country in basic health facilities, access to these structures remains difficult. There are the problems of concentration, isolation and population mobility. Similarly, if immunization is to be done at the HP level, the medical-technical equipment and the cold chain remains insufficient at the country level, and their maintenance system is not efficient. It is therefore important to bring health services to the dwelling places of the population in order to promote their use. GAVI's support will not only be used to strengthen the capacities of the structures, but also to decentralize health facilities (FS) maintenance services, and to comply with outreach trip programs.   1. ***Develop human resources in health by 2014***   To the scarcity and inadequacy of the human resources can be added low motivation, unequal distribution, and the high mobility of health personnel; this hinders the implementation of health actions, including immunization.  In order to continue educating current employees, GAVI support is necessary. Also, it will allow the assurance of a better quality of services offered, the development of the mechanisms to retain staff at their workstations, and the strengthening of the management mechanisms of the human resources for health.   1. ***Improve community participation in the implementation of health activities***   The strengthening of the capacities of community liaison personnel is necessary, in order to allow better awareness of the population with a view to their committing to health activities.   1. **By 2014, the rate of essential drug stock shortages (out-of-stock), including vaccines and inputs relating thereto, will be reduced to 0% in the targeted areas.**   The operation of the pharmacies of the health facilities is provided in most cases by unqualified personnel. This results in the low utilization of management tools, inadequate assessment of drug needs and unfit conservation. GAVI support will allow the strengthening of the capacities of management of pharmacy personnel, the building of storage shelters in order to ensure the availability of quality essential drugs for the management of PIAC cases.   1. **Improve the performance of the SIS, of the surveillance of EPI target diseases, and of the research in the health districts by 2014**   Interventions in the field of the health information system will focus on strengthening the capacities of the participants at all levels of the health pyramid, on the strengthening of the information processing material, on the provision of data collection supports, particularly at the DHC and HP levels. The retro information mechanism will be strengthened in order to promote the availability and use of quality health information in the decision-making process.  Inter-sectorial collaboration will need to be strengthened in order to improve the monitoring of vaccine-preventable diseases.  With regards to health research, GAVI's support will be used to strengthen the human resource capabilities, and to develop in them a research culture, in order to create a tool for the quality improvement of the immunization programs by improving the decision-making process based on the evidence and experiences available.  ***THREE PAGES MAXIMUM*** |
| * 1. a) Narrative description of programmatic activities   → Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.   * 1. b) Logframe   *→ Please present a logframe for this proposal as Attachment 2.*   * 1. c) Evidence base and/or lessons learned   *→ Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide details of previous experience of implementing similar activities where available.* |
| **From the analysis of the situation, seven (7) priority issues were retained. These are:**  (i) the weak organization/coordination and supervision of the health services, including the immunization programs, at every level of the health system, (ii) the lack of infrastructure, equipment, and maintenance facilities in the areas which have the lowest coverage, (iii) the insufficient quantity and quality of human health resources, (v) the poor performance of the National Health Information System (NHIS), (vi) the insufficient funding of health and low financial access of the population to the health services, (vii) low participation of the community in the health districts.  The objectives defined below stem from the abovementioned problems, and are broken down into service delivery areas (SDAs) and activities below:  **Objective 1: Improve the organization and coordination of health services, including the immunization programs at every level of the health system by 2014**  **SDA 1.1: Strengthen the capacities of the managers which are responsible for the health services**  **A.1.1.1Organize three training sessions for members of district health management teams on the methods and techniques for planning and formative supervision of staff currently in health posts and DHCs (one session per island).**This will allow more effective planning and monitoring of the development of immunization activities, and the improvement of the quality of services  **A.1.1.2: Organize planning workshops in the DHCs and the HP (Health Post).**  **SDA 1.2: Strengthen the coordination, monitoring and evaluation of HSS activities**  **A.1.2.1: Support for the organization of coordination meetings of the implementation of the GAVI HSS (one meeting per quarter and per district).** The successful implementation of activities requires coordination between the different protagonists in the area; this allows the harmonization of the interventions and avoids duplication of efforts.  **A.1.2.2: Provide the central and district health levels with vehicles for supervision.** This essentially aims to enable the coordination teams to provide technical support and monitoring to decentralized structures.  **A.1.2.3: Field support and supervision of the DHCs and the central level.** In order to assess the level to which the indicators defined in the proposal have been achieved, regular monitoring of the status of implementation of the activities in the autonomous islands, health districts and HP is required.  **A.1.2.4: Organize a mid-term review in the fourth quarter of 2013** to assess progress and overcome possible constraints  **A.1.2.5: Organize a final evaluation of the implementation of the GAVI HSS activities** in order to assess the achievement of objectives set.  **A.1.2.6: Organize an external audit of the implementation of the proposal**  **A.1.2.7: Support the advanced strategy activities.** This will entail providing fuel to the HP in the targeted areas for the performance of advanced strategies when presented with the action plans  **Objective 2: Improve the rate of district health attendance from 19% to 30%, especially for women and children under 5 years of age in targeted areas by 2014, in accordance with the established standards.**  **SDA 2.1: Upgrading of the equipment, infrastructure, and the maintenance and provision of care in the targeted areas.**  **A.2.1.1: Rehabilitate and re-equip the HPs of the targeted areas**. This is to rehabilitate and re-equip health facilities—essentially the health posts—in the targeted areas in order to provide better geographic accessibility for the population  **A.2.1.2: Provide the DHCs with motorbikes for advanced strategies.** This is to achieve the outreach activities to improve the provision of curative and preventive care.  **A.2.1.3: Provide districts with incinerators for injection safety**  **A.2.1.4: Support the preventive maintenance of medical equipment** in order to ensure the functionality of medico-technical equipment  **SDA 2.2: Development of health human resources**  **A.2.2.1: Organize three training sessions on the implementation of the essential services packages for DHC officers.** The strengthening of their capacities will improve their performance and the quality of the service provided.  **A.2.2.2: Train DHC and HP officers in preventive maintenance of equipment**  **SDA 2.3: Strengthening of social mobilization.**  **A.2.3.1: Organize 9 training sessions for the community-based health workers**. The CHW training will provide technical support to the DHC and HP in the mobilization of the population, in the epidemiological surveillance and the research of lost-to-follow-ups with regards to immunization.  **A.2.3.2: Provide the DHCs in the targeted areas with communications equipment** for community awareness and mobilization.  **A.2.3.3: Organize 3 training workshops of the management committees of the HP and DHCs of the targeted areas.** The purpose of this is to revitalize the management committees in order to better involve them in the management of health service.  **A.2.3.4: Provide the Directorate of Health Promotion with the IRC materials and supplies** for the mass awareness campaigns.  **Objective 3: By 2014, reduce the rate of essential drug stock shortages (out-of-stock), including vaccines and inputs to 0%.**  **SDA 3.1: Improve the storage conditions of medicines and vaccines**  **A.3.1.1: Provide the Independent Pharmacy (PNAC) and its branches at the islands with storage**  **facilities.** These acquisitions will allow better conservation of essential drugs, vaccines and inputs to be ensured  **A.3.1.2: Provide the HP in the targeted areas with solar refrigerators** in order to complement the support from other partners in the expansion of immunization services.  **SDA 3.2: Strengthening of the technical capacities of the pharmaceutical stores in the targeted areas**  **A.3.2.1: Organize 6 training sessions for the managers of medicines and vaccines in the use of management tools** in order to ensure better quantification of the needs and a proper management of the inventory.  **A.3.2.2: Provide the DHCs and HP in the targeted areas with the essential generic medicines.** A substantial starting grant and the training of the managers in the field of management will ensure the continued supply of medicines.  **Objective 4: Strengthen the Sanitary Information System**  **SDA 4.1: Improving the quality of the data**  **A.4.1.1: Organize three training sessions on data analysis and use for the DHC and HP information managers in the targeted areas**  **A.4.1.2: Support the assessment of data quality in the DHCs and HP**  **A.4.1.3: Provide DHCs and HP with tools for data collection.** This is in order to have reliable data for decision making  **SDA 4.2: Publication and dissemination of health information**  **A.4.2.1: Support the production and dissemination of the statistical yearbook** in order to report on achievements  **A.4.2.2: Provide the DHCs with internet connections, in order to facilitate the transmission of data**  **SDA 4.3: Development of health system research**  **A.4.3.1: Support 2 operational researches on the reasons for the non-immunization of children under 11 months in the DHCs** in order to tailor educational messages  **A.4.3.2: Publish and disseminate the results of these studies** to allow a better use of data.  **SIX PAGES MAXIMUM** |
| * 1. Main Beneficiaries   *→ Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.* |

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| **Objective 1: Improve the organization and coordination of health services, including the immunization programs at every level of the health system by 2014**  Improving the management of health services will enable better coordination of interventions to avoid duplication of efforts and better direct interventions to achieve the targets set. Mobilizing the community, as well as its involvement in the management of health services, particularly that of women, will contribute to the proper identification of the needs of the poorest populations in order to take them into account in the planning that is done with the populations themselves to find the right solution to their problem. Regular supervision is vital to the proper monitoring and enhancement of staff skills in order to improve the quality of health services. It also allows the prompt detection of those unreached populations in those areas which are not accessible, and the implementation of the appropriate strategy for providing care to those who need it in these areas of difficult access. The mid-term and end-of-period evaluations will allow us to assess the level of achievement of the goals.  **Objective 2: Improve the rate of district health attendance from 19% to 30%, especially for women and children under 5 years of age in targeted areas by 2014**  The upgrade of the technical medical equipment of the DHCs and HPs, as well as the creation of new immunization centers, demonstrates the resolve to reduce the disparities between the target areas as well as within each zone. The implementation of planned activities will address disparities in access and therefore the immunization coverage between the different populations of the areas targeted. The emphasis which will be placed on maternal and child and infant health answers the question of equity with regards to access to healthcare for women and children and infants, and takes into account the gender issue. The reasoning behind the criteria for the selection of the intervention areas lies in the desire of the Comoros health officials to reduce the inequity in access to healthcare. The development of advanced strategies is a possible solution.  **Objective 3: By 2014, reduce the rate of essential drug stock shortages (out-of-stock), including vaccines and inputs, to 0%.**  The initial grant allotted to the pharmacies in targeted areas and to the training of personnel in management will ensure the continued availability of drugs for the treatment of illnesses, particularly of PIAE cases when needed. The emphasis will be on medications for the mother and child.  **Objective 4: Strengthen the National Sanitary Information System**  The regular dissemination of information on the health of the mother and child will better allow the identification of bottlenecks and the planning of actions to meet the health needs. The training of data managers in the targeted areas in addition to those efforts which are already underway will improve the timeliness and completeness of the transfer of health information to the central level.  ***TWO PAGES MAXIMUM*** |

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| **4. Performance Monitoring and Evaluation** |
| 4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework  *→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed template) as Attachment 4.* |
| 4.2 a) M&E arrangements  *→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.*  4.2 b) Strengthening M&E systems  *→ Please describe the M&E systems strengthening activities to be funded through this proposall.* |
| **4.1 a) National Monitoring and Evaluation (M&E) Plan and Performance Framework**  There is no National Monitoring and Evaluation Plan to measure process and impact indicators for the entirety of the various programs of the Ministry of Health. However, in the framework of the support from the Global Fund, monitoring and evaluation plans for the NMCP and the DLS have been developed and are being implemented. At present, a number of impact and product indicators have been identified for the monitoring of activities (see attachment). Furthermore, the monitoring of the evolution of the immunization coverage will be performed through the information system for the routine monitoring of vaccine-preventable diseases.  As part of the implementation of the NDPHIS, an indicator harmonization process is undergoing approval in order to establish a new normative framework for the Health Information System. This will provide indicators which are within the framework of the routine collection.  Strategically, the monitoring and evaluation takes place at the level of the National Health Committee, which is a multi-sectoral body, composed of all national and international partners. Furthermore, the main mechanism for program monitoring and evaluation is based on mid-term and annual planning review meetings, which are organized by the Directorate General for Research, Planning and Statistics (DGRHP).  **4.2 b) Monitoring and Evaluation Arrangements**  The Directorate of Research and Planning monitors the implementation of HSS activities funded by GAVI in cooperation with the National Directorate of Health. These bodies meet periodically to review the reports in order to take corrective decisions in terms of guidelines and recommendations for the operational level.  Taking into account these guidelines and recommendations on the operational level contributes to the improvement of the NHDP implementation process, and more specifically to the actions which are programmed in the GAVI proposal. The operational implementation of all its actions will be carried out through supervision, controls, data and information collection trips, internal **and** external evaluations, surveys and holding of consultation frameworks at all levels. The implementation of these activities will allow for on-the-field verification of the quality of the work that is being performed, for observation of the difficulties encountered and the shortcomings of the implementation in order to find appropriate solutions. In addition to these monitoring frameworks of the NHDP, there are frameworks which are specific to immunization, such as the Interagency Coordinating Committee (IACC), which meets twice (2 times) a year to discuss issues which are related to immunization.  As part of the implementation of the National Health Development Plan (NHDP) 2010 to 2014, a list of indicators has been defined to periodically measure the performance framework in order to ensure that, in terms of results, the efforts of the players go toward the accomplishment of the plan. The indicators which are related to immunization are taken into account in monitoring indicators of the NHDP.  In addition to tracking immunization indicators, the surveillance of vaccine-preventable diseases will be strengthened in terms of epidemiological surveillance services. The indicators which are defined at this level are essentially the rate of promptness and completeness of reports, and the incidence of the patients involved.  **4.3 c) Strengthening of Monitoring and Evaluation systems**  In order to provide better quality in the actions to be undertaken, and to improve the implementation of the planned activities, it will be necessary to strengthen collaboration with technical and financial partners, civil society, the private sector, and communities. This partnership will be operationalized in terms of coordination, technical support, and of the building of competency (training in monitoring and evaluation, particularly in the areas of ​​immunization, data quality control, etc.) of the players on the ground at all levels in order to improve the quality of the expected results.  The strengthening of the health system will be accompanied by an operational research effort whose main focus will be on the reasons for non-immunization of children under one year  ***THREE PAGES MAXIMUM*** |

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| **5. Gap Analysis, Detailed Work Plan And Budget** |
| 5.1 Detailed work plan and budget  *→ Please present a detailed work plan and budget as Attachment 5.* |
| 5.2 Financial gap analysis  *→ Please present a financial gap analysis (and counterpart financing table for Global Fund applicants).* |
| 5.3 Supporting information to explain and justify the proposed budget  *→ Please include additional information on the following:*   * *Efforts to ensure Value For Money* * *Major expenditure items* * *Human Resources costs and other significant institutional costs.* |

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| 5.1 1 Detailed work plan and budget (in the attachment)  5.2 Financial gap analysis    Due to the absence of data broken down per month, we are providing a table of the contributions from the different partners in the strengthening of the health system from 2012 to 2014.  **Array of the partners involved in Health System Strengthening in the Union of Comoros**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Funding sources** | **Allocation per year in USD $** | | | | | **Year 1 of the implementation** | **Year 2 of the implementation** | **Year 3 of the implementation** | **TOTAL AMOUNT OF FUNDS** | | | **2012** | **2013** | **2014** | | GAVI | **596,605** | **601,771** | **600,889** | **1,799,265** | | Government | 440,000 | 440,000 | 440,000 | **1,320,000** | | WHO | 128,550 | 128,550 | 128,550 | **385,650** | | UNICEF | 15,000 | 15,000 | 15,000 | **45,000** | | UNFPA | 550,000 | 550,000 | 550,000 | **1,650,000** | | PASCO | 2,080,179 | 351,000 | - | **2,431,179** | | IMF | 31,536 | 37,243 | 37,898 | **106,677** | | IDB | 447,000 | 438,000 | - | **885,000** | | Qatar Funds | 6,536,000 | 5,553,000 | 4,569,480 | **16,658,480** | | Japanese Bank for International Cooperation | 873,000 | - | - | **873,000** | | **TOTAL Funds** | **11,697,870** | **8,114,564** | **6,341,817** | **26,154,251** |   The table above shows all the partners involved in strengthening the health system as well as the amount of their contribution.  The total sum of the financial contributions toward the global HSS, including those from GAVI, amounts to**$26,154,251**USD.  The Government, as well as the IDB, WHO, UNICEF, and the Global Fund donors, are involved in all aspects of the strengthening of the health system.  The UNFPA and PASCO donors are involved in the area of reproductive health. PASCO, in particular, is active in the strengthening of the health information system.  The Qatar donor is involved in the rehabilitation, reequipping, construction and equipping of health facilities.  The Japanese Bank for International Cooperation is involved in the cold chain equipment and the rehabilitation of hospitals, particularly operating theaters.  As is shown in the chart, GAVI support is complementary to the other donors in the framework of strengthening the health system.  **Technical adequacy of the proposed activities**  The proposal of the Union of Comoros for GAVI support toward the strengthening of the health system in relation to immunization is part of the implementation of the 2010–2014 NDHP and progress toward the MDGs. Its purpose is to contribute toward the improvement of the health of the general population, particularly that of the mother and child. The main purpose of the request is to strengthen the capacity of the health system to achieve the EPI objectives by 2014.  In order to achieve these objectives, 10 SDAs have been defined and distributed by objective, then broken down into 28 activities which are derived from the comprehensive multi-year plan, a specific strategic EPI document issued by the NDHP.  **2**. **Strategy for effective implementation of the proposed activities**  The implementation strategy will depend on the different levels of the health system  **2.1 Community level**  At the community level, the monitoring and evaluation activities will be performed through the HP and DHC management committees, whose general meetings will allow bottlenecks in the execution of a number of activities, including immunization activities, to be identified. Care will be taken to involve women sufficiently in the management committees. Monthly supervision of the community activities will be provided by the DHCs.  **2.2Health district and regional levels**  At the health district level, it is the MTs which will centralize the data collected in the basic health facilities and develop the quarterly reports as well as the progress reports, which they will forward through official channels to the regional level, which in turn will develop a report to be transmitted to the central level.  Every six months, supervision will be provided by the regional teams on the activities of the district MT.  Every six months, supervision will be provided by the teams from the central level on the activities of the district MT.  **2.3 Central level:**  The Directorate of Research and Planning monitors the implementation of HSS activities funded by GAVI in cooperation with the National Directorate of Health.  **3. Strategy for effective implementation of the proposed activities**  The resources which are to be deployed as part of the proposal will be managed by the NHC for the achievement of the objectives of the NHDP. The common procedures for fundraising, decision-making, disbursement mechanisms, production of activity, financial, and audit reports by the global audits will be conducted by independent auditors.  The funding procedure which has been adopted is decentralized management based on performance. The aim is to encourage people to develop a performance-oriented culture.  Strategy implemented so as to respect the complementary nature of the application funds and to avoid duplication of funding.  In addition to the comprehensive monitoring framework of the NHDP, there are frameworks which are specific to immunization, such as the IACC, which will consider issues related to immunization.  The coordination mechanism will be the same as that which is in force for the implementation of the 2010–2014 NHDP, especially since GAVI-HSS is a contribution toward the achievement of the NHDP.  ***TWO PAGES MAXIMUM*** |

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| **6. Implementation Arrangements, Capacities, and Programme Oversight** |
| **6.1 a) Lead Implementers (LI)**  *-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.*  *🡪 Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives*. |

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| **Lead Implementer:** | The National Health Committee |
| **Objective(s):** | **1)** **Improve the management and coordination of health services including immunization by 2014**  **2) Increase the attendance rate of health care facilities from 19% to 30%, especially for women and children, by 2014**  **3) Reduce the rate of out-of-stock shortages of essential drugs in the pharmacies of the public health facilities to 0%**  **4) Improve the performance of national health information system, etc.** |
| *🡪 Description of the Lead Implementer’s technical, managerial and financial capabilities.* | |
| The National Health Committee (NHC) will ensure the coordination, the monitoring, the evaluation, and the inspection of the implementation of HSS-GAVI as well as the 2010–2014 NHDP, especially since GAVI-HSS is a contribution toward the achieving of the NDHP objectives. To do this, the National Health Committee is the coordinating body for the implementation of the NHDP, and will also provide therein an integrated coordination, monitoring and evaluation, as well as a quarterly inspection of the implementation of GAVI-HSS through the NHDP.  Certain decisions and specific guidance with regards to immunization will be taken by the Interagency Coordinating Committee (IACC). The role of the NHC is to:   * Ratify the annual action plans for the implementation of the HSS/GAVI proposal; * Approve the plans for disbursement of the proposal; * Determine the direction of the Technical Committee; * Monitor the implementation of the proposal at its annual meetings; * Initiate audits on the management of the HSS-GAVI financial resources.   Initiating the annual evaluation of the implementation of the proposal on the occasion of the sector's yearly reviews. The directions and decisions taken are translated in the form of planning guidelines by the General Directorate of Studies and Planning, at the location of the intermediate and operational structures for the preparation of their annual action plans. | |

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| **6.1 b) Coordination between and among implementers** |
| 🡪*Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.* |
| The coordination mechanism will be the same as that which is in force for the implementation of the 2010–2014 NHDP, especially since GAVI-HSS is a contribution toward the achievement of the NHDP. To achieve this, at the central level, the National Health Committee (NHC), which is under the chairmanship of the Minister of Health, is the highest annual consultation forum, in which sit members from civil society, the private sector, island authorities, as well as other ministerial departments in order to review and validate the various reports. It provides strategic direction for achieving goals.  The National Technical Health Committee (NTHC) is the coordinating body for the implementation of the NHDP. It is chaired by the Director-General of Health and also provides, in an integrated manner, the coordinating and monitoring of the implementation of the GAVI-HSS through the NHDP. It also provides strategic directions for the improvement of the implementation of operational actions. Certain decisions and specific guidance with regards to immunization will be taken by the Interagency Coordinating Committee (IACC).  At the island level, there are other forums for consultation, such as the Regional Directorate of Health and the district Management Team (MT), who meet regularly in order to validate the activity reports of the basic health facilities and to provide guidance in order to improve future actions. In all of these processes, civil society is involved.  At the community level, biannual general meetings are organized by the health management committees.  The development of various monitoring reports of this implementation is coordinated by the Directorate General for Research and Planning, in cooperation with the National Health Directorate.  ***ONE PAGE MAXIMUM*** |

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| **6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*** | |
| 1. Will other departments, institutions or bodies be involved in implementation as Sub-Implementers? | * *Yes 🡪 go to section 6.1 c) (iii) and 6.1 c) (iv)* |
| *No 🡪 go to section 6.1 c) (ii)* |
| (ii) If no, why not? | |
| ***HALF-PAGE MAXIMUM*** | |
| (iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe:   * The roles and responsibilities to be fulfilled; * Past implementation experience; * Geographic coverage and a summary of the technical scope; * Challenges that could affect performance and mitigation strategies to address these challenges.  |  | | --- | | ***TWO PAGES MAXIMUM*** | | (iv) If the private sector and / or civil society are not involved in the implementation, at the sub-entity of execution, or if their involvement is limited, please explain why. | | |
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| **6.1 d)** **Strengthening implementation capacity**  (a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.  *🡪 Please refer to* [*Strengthening Implementation Capacity information note for further background and detail*](http://www.theglobalfund.org/en/application/infonotes/). | | | | |
| Management and/or technical assistance objective | Management and/or technical assistance activity | **Intended beneficiary** of management and/or technical assistance | Estimated timeline | **Estimated cost**  **(same as proposal currency)** |
| Assess the implementation rate of activities and the indicators' level of achievement | Provide technical support to the mid-term evaluation | DGRPHS | 15 days |  |
| Provide technical support to the final evaluation | DGRPHS | 15 days |  |
| Improve the performance of the health information system | Provide technical support to the external evaluation of the data quality | DIHS | 15 days |  |
| Assess the performance of the health system | Perform the selection of those indicators for the development of a national monitoring/evaluation plan | DGRPHS | 30 days |  |
| (b) Describe the process used to identify the assistance needs listed in the above table. | | | | |
| For the mid-term and final evaluations, the perspective of an outside observer will allow the bottlenecks to be better identified, in order to correct them in the achievement of the objectives.  As part of the implementation of the proposal, having quality statistical information will help ensure a clear view of the achievements and efforts put forth. In order to objectively identify the problems in this area, an external evaluation, by way of technical assistance, is necessary.  In order to avoid the proliferation of mechanisms and tools for the evaluation of interventions, it is important that all partners agree on a limited number of indicators which will measure system performance and which will be measured together for all the parties. Technical assistance is requested in order to facilitate the development of the document as well as the political dialogue for the selection of indicators.  ***HALF-PAGE MAXIMUM*** | | | | |
| (c) If no request for technical assistance is included in the proposal, provide a justification below. | | | | |
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| **6.2 Financial management arrangements**   * *Please describe:*  1. *The proposed financial management mechanism for this proposal;* 2. *The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.* 3. *Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.* |
| The funds will be placed in a HSS/GAVI special account of the GAVI EPI account, which will be opened at the Central Bank of Comoros (BCC) on behalf of the Ministry of Health. This account will work with a triple signature:   * a representative of the Ministry of Health, the Secretary General of the Ministry of Health * a representative of the technical and financial partners, the representative of the WHO in Comoros * a representative of civil society, the head of the Comoros Red Crescent   An annual work plan will be developed by the Directorate General for Research, Planning and Health Statistics (DGRPHS) in collaboration with the department of the focus area, indicating the activities to be funded by the partners and the GAVI Fund in accordance with the established work plan. This plan will be presented to the NHC for approval.  Each disbursement will be subject to a request, addressed by the structure which is responsible for the field of action in the Secretariat General of the Ministry of Health for a non-objection notice, with a copy sent to the DGRPHS for coordination. Thus referred, the request will be forwarded to the Department of Administration and Finance (DAF) of the Ministry of Health for execution.  The released funds will then be made ​​available to the structures which are responsible for the implementation of the activity. A financial report will be made ​​at the end of each activity. The supporting documents will be retained by the DAF after their compliance has been ascertained.  At the end of the implementation of the annual action plan, an internal financial audit will be commissioned to certify the accounts. This audit will be performed internally by the Finance Inspectorate and externally by financial audits performed by specialized offices which will be selected through open tender. The audit reports will be transmitted to the NHC.  **2. Mechanism for transferring funds from GAVI to the HSS of the central level to the periphery**  The funding procedure adopted in the framework of the implementation of the HSS is decentralized management based on performance. The aim is to encourage people to develop a performance-oriented culture. The transfer of the GAVI funds to the peripheral structures will obey the following rules:   * distribution of funds in accordance with the activities identified in the proposal and in accordance with the predetermined criteria; * communication of the credits granted to each structure upon receipt of funds; * development of a plan of action; * consideration and funding of the plans of action by the National Health Committee;   Funds will be transferred via bank transfers and in installments to the Regional Directorates of Health of the Autonomous Islands in accordance with the quarterly planning of health activities.  **3. The purchasing mechanism** which will be used will respect the local procedures for the acquisition of goods and services by public procurement, and will use the UNICEF and WHO for the acquisition of certain assets outside of this, in the event that this approach would offer significant advantages. For every local purchase of goods, the normal procedures will apply: prior submission of three pro forma invoices, a selection committee for awarding the contract, the establishment of purchase orders subject to financial control, and payment of the final invoice after the delivery of goods ordered.  For the sake of transparency in the management of the finances, a procedures manual will be developed by July 2012 in order to facilitate said management.  Each year in January or February, a meeting of the NHC will rule on the implementation of the GAVI support during the previous year. A summary of the activity reports of the health districts of each island will be submitted to this meeting.  An annual financial and technical report, which draws on the conclusions of the meeting of the NHC will be prepared, in accordance with the recommended form, and submitted to GAVI no later than May 15 of each year, after approval by the President of the NHC and the Director-General of Studies, Planning and Health Statistics, with copies sent to the General Planning Commission and the Ministry of Finance.  ***TWO PAGES MAXIMUM*** |
| **6.3 Governance and oversight arrangements**   * *Please describe:*  1. *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);* 2. *The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;* 3. *Plans (where appropriate) to strengthen governance and oversight;* 4. *Technical Assistance (TA) requirements to enhance the above governance processes.* |
| The governance body which was selected to coordinate and oversee the activities, including the monitoring of funding, is the National Health Committee. It will:   * Ensure the effective involvement of all parties in the implementation of the GAVI-HSS support to the HSS; * Ensure the coordination and the integration of the GAVI support to the HSS into the other health programs; * Ensure that the GAVI support to the HSS is in line with the policies and development plans of the country; * Control the use of the GAVI-HSS support funds.   A mechanism for coordinating the GAVI support to the HSS with other health system–strengthening activities and programs will be established. It will: (i) hold review and annual planning meetings of all of the development programs of the health sector, (ii) synergize and coordinate between the partners in the sector and (iii) produce and disseminate the semi-annual progress reports on the implementation of the GAVI/HSS.  The roles and responsibilities of the key partners are defined in the table below:   |  |  |  | | --- | --- | --- | | Title/Position | Organization | Roles and responsibilities of this partner in the implementation of the GAVI support to the HSS | | WHO Representative | WHO | * Technical and financial support * Support for coordination between the partners * Advocacy for the HSS | | UNICEF Representative | UNICEF | * Technical and financial support * Advocacy for the HSS | | UNFPA Representative | UNFPA | * Technical and financial support * Advocacy for the HSS | | Director | AFD/French Cooperation | Financial support, supplementary to the HSS interventions | | Executive Directors/ Coordinators | Local NGOs | Operators in charge of the implementation on the ground (contracting) |   ***ONE PAGE MAXIMUM*** |

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| **7. Risks and Unintended Consequences** | |
| **7.1 Major risks**   * *Please describe any major “internal” risks (within the control of those managing the implementation of the HSS support) and “external” risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.* | |
| **Risks** | **Mitigating strategies** |
| **Staff mobility** | **Establish a mechanism to retain staff (increase staff loyalty)** |
| **Reduction of the partners' contribution** | **Guarantee the funding pledged by the partners** |
| **No population involvement** | **Strengthen mechanisms of social mobilization** |
| **Delay in the receipt of the funds** | **Plan for the beginning of the implementation in the fourth quarter of 2012** |
| * 1. **Unintended consequences** * *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.* | |
| The implementation of interventions within the framework of the application is not without unintended consequences, in the sense that all activities which relate thereto are an integral part of the strategic direction of the 2011–2014 NHDP as well as of the comprehensive multi-year plan of the EPI.  .  ***HALF-PAGE MAXIMUM*** | |

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| **Mandatory Attachments**  *→ Please tick when the attachment is included* | | |
| *No.* | *Attachment* | ***✓*** |
| **1** | National policy, national strategy, or other documents attached to this proposal, which highlight strategic HSS interventions | ***✓*** |
| **2** | Logframe |  |
| **3** | National M&E Plan |  |
| **4** | Performance Framework |  |
| **5** | Financial gap analysis, detailed work plan and detailed budget | ***✓*** |

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| **Optional Attachments**  *→ Please tick when the attachment is included* | | |
| *No.* | *Attachment* | ***✓*** |
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Appendixes:

**Performance framework**

**Impact indicators**

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| **Indicators** | **Source of the data** | **[Value of the baseline](" \l "RANGE!#REF!)** | **[[6]](#footnote-6)Source** | **Date of the baseline** | **Objective** | **Deadline** |
| 1. National immunization coverage with DPT-HepB3 | CNPEV | 74.71 | JRF | 2011 | 93 | 2014 |
| 2. Number of districts achieving a coverage level of ≥ 80% in DPC-HepB3 | CEPEV | 9 | JRF | 2011 | 17 | 2014 |
| 3. Rate of infant mortality (per 1000) | CGP | 83.2 | RGPH | 2003 | 40 | 2014 |
| Mortality rate of children under 5 (per thousand) | CGP | 112.9 | RGPH | 2003 | 50 | 2014 |
| 4. Number of districts reporting a DTC dropout rate of over 10% | CNPEV | 6 | JRF | 2011 | 0 | 2014 |
| 5. TT2 + Immunization coverage of pregnant women (with at least 2 doses of tetanus toxoid) (%) | CNPEV | 45.7 | JRF | 2011 | 65 | 2014 |
| 6. Rate of attendance of health care facilities | Statistical reports | 0.19 | DHC evaluation reports | 2007 | 0.30 | 2014 |

**Output indicators**

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| **Indicators** | **Source of the data** | [**Value of the baseline**](#RANGE!#REF!) | **[[7]](#footnote-7)Source** | **Date of the baseline** | **Objective** | **Deadline** |
| 1. Percentage of posts and district health centers which offer the full PMA | Activity report | 0 | Evaluation report | 2011 | 100 | 2014 |
| 2. Rate of availability of essential drugs | CNPEV | 0 | JRF | 2011 | 100 | 2014 |
| 3. Proportion of health posts and DHCs which have the requisite number of staff | Activity report | 0 | District evaluation report | 2012 | 90 | 2014 |

**Process indicators**

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| **Indicators** | **Source of the data** | [**Value of the baseline**](#RANGE!#REF!) | **[[8]](#footnote-8)Source** | **Date of the baseline** | **Objective** | **Deadline** |
| 1. Percentage of health posts and district health centers that have received the initial stock of essential generic drugs (EGD) | Activity report | 0 | Evaluation report | 2012 | 100 | 2014 |
| 2. Percentage of training supervision conducted from the Central Level to the DGS | Activity report  Supervision report | 0 | Activity report | 2012 | 80 | 2014 |
| 3. Percentage of the members of the management teams which are trained (one indicator by type of training) | Reports of the training sessions  Annual activity reports of the DHCs | 0 | District evaluation report | 2012 | 100 | 2014 |
| 4. Percentage of supervisory training conducted by DGS to the DHCs | Activity report | 0 | Activity report | 2012 | 100 | 2014 |
| 5. Percentage of supervisory training conducted by DHCs to the HP | Activity report | 0 | Activity report | 2012 | 100 | 2014 |
| 6. Percentage of reviews conducted (annual and mid-term) | Activity report | 0 | Activity report | 2012 | 100 | 2014 |
| 7. Percent of DHCs whose cost recovery system has been reviewed | Activity report | 0 | Activity report | 2012 | 100 | 2014 |

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| **Appendix 5: Summary table of the work plan and budget (See matrix for details)** | | | | | | | | | | | | | | | | | |
| **Area of support** | **Activities** | ***Work plan*** | | | | | | | | | | | | ***Budget in USD*** | | | |
| **Y1** | **Y1** | **Y1** | **Y1** | **Y2** | **Y2** | **Y2** | **Y2** | **Y3** | **Y3** | **Y3** | **Y3** | **Year 1** | **Year 2** | **Year 3** | **TOTAL COSTS** |
| **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **2012** | **2013** | **2014** |
| **Objective no.1**:**Improve the organization and coordination of health services, including the immunization programs at every level of the health system** | | | | | | | | | | | | | | **188,949** | **141,227** | **419,653** | **749,829** |
| **SDA1.1:**Strengthen the capacities of the managers which are responsible for the health services | A.1.1.1: Organize three training sessions for members of the district health management teams on the methods and techniques for planning and formative supervision of staff currently in health posts and DHCs (one session per island) |  |  |  | X |  |  |  |  |  |  |  |  | 11,976 |  |  | **11,976** |
| A.1.1.2: Organize planning workshops in the DHCs and the HP. |  |  |  | x |  |  |  | x |  |  |  | x | 7,795 | 8,404 | 9,059 | **25,258** |
| **SDA 1.2:** Strengthen the coordination, monitoring, and evaluation of HSS activities | A.1.2.1: Support the organization of coordination meetings of the implementation of the GAVI HSS (one meeting per quarter and per district). |  |  |  | x | x | x | x | x | x | x | x | x | 2,188 | 9,436 | 10,172 | **21,795** |
| A.1.2.2. Provide the central and district levels with vehicles for supervision. |  |  |  | X |  |  |  |  |  |  |  |  | 142,443 |  | 264,849 | **407,292** |
| A.1.2.3. Field support and supervision of the DHCs and the central level. |  |  |  | X |  | x |  | x |  | x |  | x | 24,546 | 52,922 | 57,050 | **134,518** |
| A.1.2.4. Organize a mid-term evaluation in the fourth quarter of 2013. |  |  |  |  |  |  |  |  | X |  |  |  |  |  | 13,686 | **13,686** |
| A.1.2.5. Organize a final evaluation of the implementation of the GAVI HSS activities |  |  |  |  |  |  |  |  |  |  |  | X |  |  | 13,686 | **13,686** |
| A.1.2.6. Organize an external audit of the implementation of the proposal |  |  |  |  |  | X |  |  |  |  |  |  |  | 23,016 |  | **23,016** |
| A.1.2.7. Support the advanced strategy activities. |  |  |  |  |  | X |  | X |  | X |  | X |  | 47,450 | 51,151 | **98,601** |

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| **Area of support** | **Activities** | ***Work plan*** | | | | | | | | | | | | ***Budget in USD*** | | | |
| **Y1** | **Y1** | **Y1** | **Y1** | **Y2** | **Y2** | **Y2** | **Y2** | **Y3** | **Y3** | **Y3** | **Y3** | **Year 1** | **Year 2** | **Year 3** | **TOTAL COSTS** |
| **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **2012** | **2013** | **2014** |
| **Objective no.2**: **By 2014, the rate of district health attendance will increase from 19% to 30%, especially for women and children under 5 years of age in targeted areas** | | | | | | | | | | | | | | **407,656** | **197,010** | **137,150** | **741,815** |
| **SDA 2.1:** Strengthening of the equipment and infrastructure, as well as maintaining and providing health services | A.2.1.1. Rehabilitate and re-equip the health posts in the targeted areas |  |  |  | X | X |  |  |  |  |  |  |  | 263,006 | 113,408 | 91,690 | **468,104** |
| A.2.1.2. Equip the DHCs with motorcycles for advanced strategy |  |  |  | X |  |  |  |  |  |  |  |  | 23,144 |  |  | **23,144** |
| A.2.1.3. Provide districts with incinerators for injection safety |  |  |  | X |  |  |  |  |  |  |  |  | 71,012 |  |  | **71,012** |
| A.2.1.4. Support the preventive maintenance of medical equipment |  |  |  |  | X |  | X |  | X |  | X |  |  | 22,682 | 24,451 | **47,132** |
| **SDA 2.2:** Development of health human resources | A.2.2.1. Organize three training sessions on the implementation of the essential services packages for DHC officers. |  |  |  | X |  |  |  |  |  |  |  |  | 12,150 |  |  | **12,150** |
| A.2.2.2. Train DHC and HP officers in preventive maintenance of equipment |  |  |  |  | X |  |  |  |  |  |  |  |  | 10,114 |  | **10,114** |
| **SDA 2.3:** Strengthening of social mobilization. | A.2.3.1. Organize nine training sessions for the community health agents. |  |  |  | X | X |  |  |  |  |  |  |  | 18,078 | 19,488 | 21,009 | **58,575** |
| A.2.3.2. Provide the DHCs in the target areas with communications equipment for the promotion of health and the mobilization and awareness of the community |  |  |  | X |  |  |  |  |  |  |  |  | 20,266 |  |  | **20,266** |
| A.2.3.3. Organize six training workshops for the management committees of the DHCs and HP |  |  |  |  | X |  |  |  |  |  |  |  |  | 20,605 |  | **20,605** |
| A.2.3.4. Provide the Directorate of Health Promotion with the IRC materials and supplies for the mass awareness campaigns |  |  |  |  |  |  |  |  |  |  |  |  |  | 10,713 |  | **10,713** |

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| **Area of support** | **Activities** | ***Work plan*** | | | | | | | | | | | | ***Budget in USD*** | | | |
| **Y1** | **Y1** | **Y1** | **Y1** | **Y2** | **Y2** | **Y2** | **Y2** | **Y3** | **Y3** | **Y3** | **Y3** | **Year 1** | **Year 2** | **Year 3** | **TOTAL COSTS** |
| **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **2012** | **2013** | **2014** |
| **Objective no.3:** By 2014, reduce the rate of essential drug stock shortages (out-of-stock), including vaccines and inputs, to 0%. | | | | | | | | | | | | | |  | **192,733** | **9,104** | **201,837** |
| **SDA 3.1:** Improve the storage conditions of medicines and vaccines | A 3.1.1. Provide the Independent Pharmacy (PNAC) and its branches on the islands with storage facilities. |  |  |  |  |  |  | X |  |  |  |  |  |  | 124,749 |  | **124,749** |
| A.3.1.2. Provide the HP in the targeted areas with solar refrigerators |  |  |  |  |  |  |  | X |  |  |  |  |  | 20,413 |  | **20,413** |
| **SDA 3.2:** Strengthening of the technical capacities of the pharmaceutical stores in the targeted areas | A.3.2.1. Organize six training sessions for the managers of medicines and vaccines in the use of the management tools |  |  |  |  | X |  |  |  | X |  |  |  |  | 8,445 |  | **8,445** |
| A.3.2.2. Provide the HP in the targeted areas with the essential generic medicines. |  |  |  |  |  | X |  |  |  |  |  |  |  | 39,126 | 9,104 | **48,229** |
| **Objective no.4:Strengthen the Sanitary Information System** | | | | | | | | | | | | | |  | **70,801** | **34,983** | **105,784** |
| **SDA 4.1:** Improving the quality of the data | A.4.1.1. Organize two training sessions on data analysis and use for the DHC and HP information managers |  |  |  |  |  |  |  |  | X |  |  |  |  | 2,815 |  | **2,815** |
| A.4.1.2. Support the assessment of data quality in the DHCs and HP of the targeted areas |  |  |  |  |  |  |  | X |  |  |  | X |  | 12,696 |  | **12,696** |
| A.4.1.3. Provide the DHCs and HP with tools for data collection. |  |  |  |  | X |  |  |  | X |  |  |  |  | 2,744 | 2,958 | **5,702** |
| **SDA 4.2:** Publication and dissemination of health information | A.4.2.1. Support the production and dissemination of the statistical yearbook in order to report the achievements |  |  |  |  |  |  |  | X |  |  |  | X |  | 14,176 | 15,282 | **29,458** |
| A.4.2.2. Provide the CNPEV and the DHCs in the targeted areas with internet connections, in order to facilitate the transmission of data |  |  |  |  | X |  |  |  |  |  |  |  |  | 22,839 |  | **22,839** |
| **SDA 4.3:** Development of health system research | A.4.3.1. Support two operational researches on the reasons for non immunization of children under 11 months in the DHCs |  |  |  |  | X |  |  |  | X |  |  |  |  | 12,696 | 13,686 | **26,382** |
| A.4.3.2. Publish and disseminate the results of these studies |  |  |  |  |  | X |  |  |  | X |  |  |  | 2,835 | 3,056 | **5,892** |
| **TOTAL COST OF THE PROPOSAL** | | | | | | | | | | | | | | **596,605** | **601,771** | **600,889** | **1,799,265** |

1. Report of the Validation Survey on the elimination of neonatal tetanus in the Comoros, Ministry of Health, November 2009. [↑](#footnote-ref-1)
2. RGPH, 2003 [↑](#footnote-ref-2)
3. Evaluation report of the nutritional status of children under 5 years, UNICEF, 2008. [↑](#footnote-ref-3)
4. EPI report, 2009 [↑](#footnote-ref-4)
5. *Source: Health District Rapid Assessment Report in 2007* [↑](#footnote-ref-5)
6. [↑](#footnote-ref-6)
7. [↑](#footnote-ref-7)
8. [↑](#footnote-ref-8)