

**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 on15 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 AND SOCIAL WELFARE*** | | | |
| **Country:** | ***LIBERIA*** | | | |
| **WHO region:** | ***AFRO*** | | | |
| **Proposal title:** | ***GAVI HEALTH SYSTEM STRENGTHENING*** | | | |
| **Proposed start date:** | ***JULY 2012*** | | | |
| **Duration of support requested:** | ***JUNE 2015*** | | | |
| **Funding request:** | **Amount requested from GAVI:** | **USD 5,400,000** | **Amount requested from Global Fund:** |  |
| **Currency:** |  | |  | |

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| **Contact details** | |
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| **Executive Summary**  *→ Please provide an executive summary of the proposal.*  The health status of Liberians is improving after a prolonged conflict. While still high, the under-5 mortality rate has declined from 220 per 1,000 live births in 1986 to 110 per 1,000 live births in 2007. Malaria prevalence in children has also declined from 66 in 2005 (LMIS) to 32 percent and access to prompt and effective treatment for malaria has increased. However, the maternal mortality rate remains very high (994 per 100,000), full immunization coverage remains inadequate (51 percent) and the HIV prevalence (1.5 percent) poses a potential threat to the population (3,476,608), of which 52 percent are 19 years of age or younger and 47 percent live in urban areas.  The purpose of the proposal is to submit Liberia’s request to GAVI for Health Systems Strengthening Support (HSS) within the renewed GAVI Phase commitment for 2012-2017 in line with the National Health and Social Welfare Plan 2011 – 2021 and the cMYP 2011 -2016. The main goal of the GAVI proposal is to complement government’s effort to improve the health and social welfare status of the population of Liberia on an equitable basis especially women and children by implementing interventions which will significantly reduce infant, childhood and maternal mortality and morbidity aimed at reaching the MDGs. The GAVI HSS proposal objectives are 1) Increase access and utilization of Essential Package of Health Services (EPHS); 2); Strengthen and operationalize a well coordinated M&E and Health Management Information System; 3). Strengthen procurement and financial management Systems; and 4). Enhance MOHSW logistical, human resource and technical capacity.  The ultimate goal of the HSS is to strengthen the health systems to provide quality maternal and child health services by increasing access and utilization of available services to underserved population. In order to meet this goal, four objectives have been derived based on assessment of the six health systems building blocks. Challenges identified will be addressed by implementing key strategies identified by the HSS proposal.  *Objective 1:* Increase access and utilization of Essential Package of Health Services (EPHS**).** This objective addresses the HSS challenges identified in the health services and human resources for health building blocks that contributed to low immunization coverage. The proposal earmarked three service delivery areas (SDA) with twelve key activities that will increase access to the EPHS. The main strategy identified to increase access is the community health program through the use of community health volunteers.  Objective 2: Strengthening and making operational a well coordinated M&E and HMIS. The purpose of this objective is to address systematic weaknesses associated with monitoring, evaluation and health management information. Twelve major activities have been listed in service delivery area 2.1 as strategies for improving health system monitoring, evaluation and research.  Objective 3: Strengthen procurement and financial management Systems.This objective is intended to address procurement issues related to frequent stock out of essential drugs and supplies within the health systems. Financial transparency and accountability of resources are crucial for external and local resource mobilization and trust.  Objective 4: Enhance MOHSW logistical, human resource and technical capacity.Limited skilled health workers and inadequate logistics have impeded immunization service delivery. To address these constraints, two service delivery areas were identified with strategies to increase vaccines uptake and strengthening of the entire health system. The procurement of vehicles for monitoring and supervision, motorcycles for outreach services, cold chain equipment, refrigerators and communication equipment will improve immunization services.  The main indicators for measuring progress of implementation of activities remain the coverage of Penta-3, followed by the percentage of fully immunized children and increase facility based reporting. These indicators will be reviewed by the HSCC and ICC annually.  The total amount requested for the GAVI HSS support is U$ 5,400,000. The yearly threshold for one year (i.e for the fiscal year July 2012-June 2013) is US$ 1,800,000.  The proposal was developed through an interactive and inclusive process of both government and partners. It addresses immunization and health sector challenges within the context of the six health systems building blocks. The proposal was reviewed and endorsed by the National Health Sector Coordination Committee and the ICC as per the GAVI guidelines.  Progress report will be sent to GAVI using the GAVI Annual Progress Reporting Format. |
| ***TWO PAGES MAXIMUM*** |

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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. Summary of the proposal development process   *→ 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.*  In response to GAVI’s call for proposal for Health Systems Strengthening, the four key departments in the MOHSW met to discuss an approach for the development of the proposal based on GAVI’s guidelines. The four departments submitted concept notes for the proposal writing process. Based on track records and previous partnerships with the World Health Organization, United Nations Children Fund and Clinton’s Global Health Access Initiatives, these three organizations were invited to participate in a priority setting process based on the concept notes provided by the four departments of the MOHSW. Each of the four departments of the MOHSW produced concept papers with work plan and budget estimates.  The second phase of this transparent process was to ensure the HSCC over sight for proposal development as required by GAVI. An extraordinary meeting of the HSCC was held in the MOHSW conference room (Minutes attached). A presentation on the framework and proposed priority areas were presented for endorsement by the HSCC. The HSCC then mandated a technical team to develop the proposal.  With the participation of various stakeholders, the HSCC decided to promote the Common Proposal framework for the country. The Technical team was formed to ensure that the proposal addresses the priority needs of Liberian society and that best practices were employed to address those needs. The membership of the technical team included the MOHSW, WHO, UNICEF, CHAI and MERLIN, who is currently the Chair of the International NGOs along with CHAL a Civil Society Organization. The technical team had weekly meetings to discuss the technical aspects of the proposal. After each meeting, a specific course of action pertaining to the content and process of the grant development was recommended to the HSCC. The HSCC and the technical team remained actively involved in the grant oversight process.  The Health Sector Coordinating Committee has a broad-based membership, representing non-  Governmental organizations, civil society, government, academic institutions, multi-lateral and bi-lateral development agencies, and other relevant partners. The Chair of the HSCC is the Minister of Health and Social Welfare. The HSCC meets quarterly and extraordinary meetings may be call as necessary to address critical issues. Also, Ad hoc or emergency meeting(s) may be suggested by any HSCC member. Decision-making is generally based on a desire for consensus. If consensus is not possible, any HSCC member can call for a vote. In order to pass, motions require a simple majority of those present.  The technical team drafting the proposal and circulated for comments to major stakeholders, including HSCC members. Inputs were received and incorporated. Following the refinement of the proposal, a presentation was made at the Ministry’s Program Coordination Team (PCT) meeting for MOHSW endorsement. The PCT is the second highest decision making forum at the Ministry, next to the Minister and Deputy Ministers meeting. |
| ***ONE PAGE MAXIMUM*** |
| 1.2 Summary of the decision-making process  *→ Please summarise how key decisions were reached for the proposal development.*  The process leading to the development of this GAVI HSS proposal started in November after the MOHSW received communication from the GAVI as being eligible to apply for GAVI HSS funding to cover a period of three years. In the first stage, the four departments of the MOHSW did a gap analysis of their 2-years operational plan. Concept notes including proposed budget for consideration followed.  Phase two was priority setting exercise which included revision of departments’ proposals and budget by a core team of partners and MOHSW members. From this exercise originated a draft revised service delivery areas with proposed budgets and work plan.  The third phase sought the HSCC endorsement of proposed service delivery areas and work plan.  The fourth phase of this process was a presentation of the proposal to the Health Coordination Committee (HCC). Following the presentation of the proposal a number of comments and suggestions were made and the proposal was then endorsed by the HCC. These comments were later incorporated and the proposal refined and finalize for GAVI’s consideration.  All objectives and strategies presented in this proposal were therefore endorsed through discussions and agreed upon by all stakeholders. |
| ***ONE PAGE MAXIMUM*** |

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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.*  Liberia is situated on the West coast of Africa, bounded by Guinea to the North, Cote D’Ivoire to the East, Sierra Leone to the West, and the Atlantic Ocean to the South. It is a relatively small nation, covering approximately 111,369 square kilometers and has a population (3,476, 608) of fewer than four million people of which 104,978 are children less than one year (2008 Population Census). The country is divided into 15 political sub-divisions, called counties: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, Rivercess, River Gee and Sinoe. Monrovia is Liberia’s largest city and serves as its administrative, commercial, and financial capital.  Malaria is the leading cause of morbidity and mortality, followed by diarrhea and acute respiratory infections (ARI). Other preventable problems that are commonly found in Liberia include tuberculosis, sexually transmitted infections, worms, skin diseases, under-nutrition, and anemia. The national HIV prevalence is currently estimated at 1.5 percent (LDHS 2007), although the recent antenatal clinic (ANC) sentinel survey indicates an HIV prevalence of 5.4 percent. The 2008 WHO-estimated incidence rate for all forms of tuberculosis was 326 per 100,000, smear positives were 132 per 100,000 and the mortality estimate was 28 per 100,000. Results of epidemiological mapping of neglected tropical diseases (NTDs) show a wide distribution and overlap of onchocerciasis, lymphatic filariasis, schistosomiasis and leprosy in all 15 counties.  While still high, under-5 mortality rate has declined from 220 per 1,000 live births in 1986 to 110 per 1,000 live births in 2007, while infant mortality rate declined from 144 deaths per 1,000 live births in 1986 to 71 deaths per 1,000 live births in 2007. With this progress, it is anticipated that Liberia might likely achieve MDG 4. Malaria prevalence in children has declined from 64 to 32 percent and access to prompt and effective treatment for malaria has increased. On the other hand, full immunization coverage remains inadequate (51 percent) and the HIV prevalence (1.5 percent) poses a potential threat to the population (3,476,608), of which 52 percent are 19 years of age or younger and 47 percent live in urban areas.  In 2009, a national human resources census recorded 8,553 health and social welfare workers. Of those who reported their cadre, 62 percent (5,346) were clinical and 38 percent (3,207) were non-clinical (including security guards, registrars and cleaners). However, only 48 percent (2,568) of the clinical workers were skilled providers (e.g., physicians, physician assistants, nurses, midwives, pharmacists, lab technicians) and almost 70 percent of the total workforce was either non-clinical or unskilled. The 2009 national human resource for health census recorded 90 medical doctors, 286 physician assistance, 1,393 nurses, 412 certified midwives and 46 pharmacists. There are nine (9) health training schools which include one medical school and one school of Pharmacy. Progress has been made in expanding the number and quality of pre-service training institutions in order to increase their capacity to produce more skilled workers.  In 2008, total health expenditure reached over US$ 100 million (or US$ 29 per person), or 15 percent of GDP. This was an unprecedented level of expenditure for Liberia and in line with the West and Central Africa Region average in 2006 (US$ 28 per person (WHO). External donors and households largely accounted for the high levels of expenditure (47 and 35 percent respectively), while government spending accounted for 15 percent. Government spending has remained stable as a percentage of the national budget (between 7 and 8 percent), but it nearly doubled in absolute terms. Donor funds are predominantly used to support service delivery at the primary care level, while referral hospitals consume the largest portion of government expenditure. See Table 1.1 on national government health budget.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Table 1.1 Government of Liberia Health Budget, FYs 2006 - 2010, in US$ | | | | | | **Fiscal Year** | **2007 – 2008** | **2008 - 2009** | **2009 - 2010** | **2010 - 2011** | | Total Government Budget | $208,819,357 | $298,087,792 | $347,035,687 | $369,379,000 | | Total Health Budget | $18,705,242 | $22,906,608 | $25,767,030 | $32,480,992 | | Anticipated health budget | $10,000,000 | $18,000,000 | $28,000,000 | $33,000,000 | | Anticipated % of total budget | 8.00% | 12.00% | 15.00% | 15.00% | | Actual percent of total | 8.96% | 7.68% | 7.42% | 8.79% |   The Ministry of Health and Social Welfare (MOHSW) directs policy, sets standards, mobilizes and allocates resources, aggregate planning, monitoring and research for the health care delivery system. The MOHSW has four departments: Health Services, Administration; Social Welfare; Planning, Research and Development. At the operational level, county health teams manage health services in the counties; district health teams supervise health services at the district level, and coordinate community health workers at the community level. Primary Health Care complemented by social welfare services forms the foundation and model for improving service delivery. Referrals are from the primary level to the secondary level and from the secondary level to the tertiary level. The private sector, faith-based facilities, facilities sponsored by international and national NGOs, and private individual practitioners are major contributors to the health care delivery system. However, the private for-profit sector is relatively poorly developed relative to other countries in the region. The 2011 accreditation report of the Ministry of Health and Social Welfare shows that Liberia’s estimated 3.5 million populations is currently served by 531 functional health facilities. A further distribution of health facilities by ownership and management indicates that 376 of the facilities are government managed of which 84% met standards for the Basic Package of Health Services (BPHS) accreditation, compared to 34% of a 155 private facilities (including Faith Based Facilities). These facilities, with a combined national professional workforce of 2,652 continue to demonstrate unwavering commitment in support of health care delivery.  The health sector has three distinct levels of service delivery, the primary level, secondary level, and tertiary level. At the primary level, clinics are to serve a population between 3,500 to 12,000 people with services that include promotional health, basic mental health services and the management of common conditions for children and adults, including basic emergency obstetrics care at the health center. The secondary level is composed of first and second tiers of referral, health centers and hospitals. Health centers (HCs) are facilities that offer 24-hour primary care services complemented with inpatient care (up to 40 beds) and laboratory for catchment populations of 25,000 to 40,000 beneficiaries. Most HCs and all district hospitals should provide Basic Emergency Obstetric and Newborn Care (BEmONC). The County Hospital is the main referral facility. The only tertiary level is the John F. Kennedy Medical Center in Monrovia and includes specialist services not provided at the secondary level of care. The JFKMC, the National Referral Hospital, plays the role of specialized referral facility and teaching hospital for physicians, MD specialties, and other specialties, in collaboration with regional-level facilities.  Community health services remain a critical input of the health system. They complement the network of health facilities ensuring that most catchment population have at least a minimum level of access to health care. Based in communities not directly served by health facilities, community health volunteers and household health promoters work with the formal health sector on health promotion, early recognition, management of referral of common conditions and provision of support to health services at the health facility or by outreach.   * 1. b) National Health Strategy or Plan   *→ Please highlight the goals and objectives of the National Health Strategy or Plan.*  The National Health and Social Welfare Plan is a ten-year plan (2011-2021) that has an overall goal of improving Health and Social Welfare status of Liberians on an equitable basis. The plan objectives are 1). to increase access and utilization of health and social welfare services, 2). improve responsiveness to people’s expectations by increasing equity and by taking decision making closer to the community, and 3). to make services available at a cost affordable to the country. In terms of service provision, the plan aims at ensuring basic health services are within 5km of most communities, strengthening the existing services to increase coverage and utilization, and expanding the EPHS with additional services in an incremental manner.  Over the next ten years, a number of small clinics (PHC level 1) will be built and outreach services delivered in communities currently underserved. Upgrading clinics to health centers will ensure that the network has the technical capacity to implement the priority programs. High-quality referral services will reach counties through the upgrading of some county hospitals to regional ones. A more complex network requires restructuring; health services will be organized in hierarchical, county and sub-county systems. Overall, the network will be composed of more than 500 public health facilities, an increase of almost 40 percent from the present situation. Human resources are expected to increase in relation to the expansion of health services.  *Quality improvement and new ways of reaching target populations is the hallmark for strengthening maternal and child care services. Contents of health services packages will be shaped with prevalence assessments of non-communicable diseases like hypertension and diabetes likely to become major public health problems in the future. Other services—mental health, neglected tropical diseases, school health, prison health, among others—will be added to the essential package.*  The hospital sector will be revised in detail. A 10-year development plan will be produced for every hospital. Health and social welfare promotion will be strengthened through empowerment of individuals and communities, multi-sectoral collaboration, and targeted community interventions.  Direct provision of social services will reach rural areas by deploying social workers at health facilities and by ensuring their presence at district level. Partners through performance-based contracts will provide institution-based (orphanages, foster care homes, residential centers) services to ensure efficiency and quality.  Regarding health financing, the MOHSW will increase resource mobilization and predictability by improving budget execution, expanding the number of donors using budget support mechanisms, and by exploring alternative financial sources such as pre-payment schemes. It is expected that equity and efficiency in resource allocation and utilization will be improved with the development of allocation formulas and by using performance-based contracts.  Human resources will remain the system’s biggest asset. Rationalization measures (development of workload indicators, establishment of performance standards) will shape county and facility deployment. In remote areas, retention will be sought by a combination of incentives. It is expected that the MOHSW will develop a 10-year training plan. Professional associations will be strengthened.  Under the supervision of the MOHSW Procurement Unit, drugs and commodities will be centrally procured by the National Drug Service and distributed to facilities through a network of county depots. Responsiveness to clients (providers) will be guaranteed by allocation of drugs funds to the County Health and Social Welfare Teams.  The Health Management Information System will be expanded to include data and indicators on social welfare, human resources, drugs, facilities and expenditure. Use of information for decision-making will be strengthened in operational planning exercises. Reports of timeliness and quality will be improved.  Some cross cutting system components will be strengthened. Quality assurance will be institutionalized, patient safety improved and quality of practice enhanced. A common annual planning cycle for the health sector will be developed and implemented. Supervision will be strengthened with the rolling out and institutionalization of the standard operating procedures. A National Research Agenda will be designed; research activities will be part of annual operational plans. Emergency Preparedness and Response will expand its scope, and annually updated contingency plans will include man-made disasters.  Following a comprehensive functional analysis of the MOHSW at all levels, it is expected that a de-concentration package will be prepared to ensure all county health teams are endowed with sufficient capacities to manage a decentralized heath and social welfare services.  The 10years national Health plan will be implemented through annual operational plans. The overall period is divided into three phases. The first three years will be devoted to developing the many plans and pilots that will shape service performance and the systemic components. During the second phase of two years, new services will be added and implementation of sub sector plans will start. After a medium term revision in the fifth year, the remaining period will be devoted to implementation.  There is a Country Multi Year Plan (cMYP) that is being implemented to boost immunization coverage.  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  There exist a 5-year HMIS Policy and Strategy that is being implemented to improve data quality and monitoring and evaluation. The HMIS is currently decentralized, with clear and harmonized reporting instruments and reporting channels. The system is gradually improving but is faced with capacity constrains (e.g., HR, logistics, infrastructure, etc).  In an effort to address the enormous human resource challenges in Liberia, a 10-year National Resources for Health Policy and Strategy (2011-2021) have been developed to tackle the issues of production, recruitment and retention, motivation, better planning, strengthening of the capacity of health training institutions, improve quality and equitable distribution of the health workforce.  There is a 10-year health financing policy and strategy (2011-2021) formulated to ensure equitable and sustainable allocation of resources by level of care. It is also designed to harness the right balance between promotive, preventive, curative and rehabilitative care and improve planning and budgeting, increase social protection and various funding mechanisms.  Althoughthe health sector is recovering from a protracted period of conflict that devastated basic health infrastructure in the country,structures and systems,have been set up to sustain and increase availability, affordability and accessibility of essential medicines, commodities, supplies. Also, Supply Chain Master Plan and a draft drug policy are available to ensure medical and non-medical products and supplies at all levels of health service delivery.  There is a community health policy and vehicle policy that are in place to address vehicle maintenance and community health services. |
| ***FOUR PAGES MAXIMUM*** |
| 2.2 Key Health Systems Constraints  *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).*  Poor infrastructure, urban-rural and education disparities are key factors which limit interventions to reducing maternal and under-fives deaths. A Rapid Maternal Needs Assessment conducted for the Operational Plan to Reduce Maternal and Neonatal Mortality reveals that maternal mortality is affected by inadequate facilities, equipment and drug supplies; health workers’ inability to perform essential procedures; lack of adequate transport system; and lack of alignment between traditional practices and standard of care. Achieving universal access to reproductive health provides the enabling environment for long term successes in child bearing, development and adulthood.  Other specific challenges include:   * A large but imbalanced service-delivery facility network that leaves out a large portion of the population, especially in rural areas. * Limited access to facilities that results in most rural households being out of reach from skilled providers, requiring a controlled redistribution of the network. * Long waiting times, poor health worker attitudes toward patients and a lack of drugs that result in low service utilization. * The now large workforce cannot deliver quality health services without a massive effort to upgrade their skills. Priority workers will remain in short supply until production of workers with the right skills mix and effective motivation and remuneration prevail. * Institutional capacity is imbalanced in favor of the central ministry over the counties as well as imbalanced among the counties.   There has been gradual progress over the past six years towards the achievement of MDG 4, 5, and 6. However, with the current challenges, it is unlikely that most of these goals might not be attained. The situation analysis, the EPI and the health sector review in 2010, have identified major challenges at the different levels of health management and delivery. With Maternal and Child Health services, malaria and HIV/AIDS constituting the bulk of total health service delivery in the country. These health conditions including key health systems constraints are restraining Liberia from achieving MDG 4, 5 and 6.   |  |  | | --- | --- | | **Building block** | **Key health systems constraints** | | Health services | * Inadequate access due to distance, geographical area and human resources to conduct regular outreach sessions * Immunization coverage variations across counties and districts because poor network of health facilities and limited immunization outreach services * Inadequate supportive supervision. * Limited use of existing clinical guidelines and protocols * Inadequate referral system | | Health workforce | * Mal-distribution of skilled health workforce particularly in the rural areas. * In sufficient motivation and retention of health workforce * Majority of the facility clinics have one qualified and one vaccinator that pose challenge for outreach services. * Limited health training institutions with uneven distribution hampers adequate enrolment and production of health workers. * Low incentive and staff motivation leading to migration and low quality | | Health information | * Limited use of health facility data at the facility, district and county levels * Weak feedback mechanism * CHDC and CHC are not used optimally to provide communities access to reports Limited qualified staff at all levels of reporting (health facility, district, county and central) * Inadequate incentive and motivation for ensuring quality and timely data collection and reporting * Inadequate operational research to guide the programs interventions * Insufficient dissemination of data or information | | Medical products, vaccines & technologies | * Frequent stock out of essential medicines and supplies * Limited number of pharmacists (46) * Inadequate capacities (limited refrigerators, cold boxes, transport, etc) at county and district levels in managing the distribution of vaccines and related supplies * Inadequate cold chain capacity at the county level to meet the vaccine requirements of the country * Inadequate information on the quality, safety and efficacy of essential medicines including vaccines * Limited number of logisticians | | Health financing | * Health sector is underfunded with out of packet expenditure reaching 35% of total health expenditure and national government budgetary allocation not exceeding 8% over the past 6 years * Delays in disbursement of the committed funds and low absorptive capacity at all levels * Limited capacities in evidence based planning and budgeting particularly at the county level * Unpredictable health sector financing | | Leadership & governance | * Insufficient dissemination national health policies and plans * Weak leadership at operational level, including poor coordination * Feedback mechanisms from national to operational levels are limited * Inadequate quality supportive supervision at all levels * Limited analysis and use of information at the operational levels (community, health facility and county) * Inadequate engagement of for-profit private sector or not-for-profit private sector not directly funded by MOHSW or major donors | |
| ***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.*  There are efforts by national government, development partners and donors to support health system strengthening in the midst of enormous challenges following a prolonged period of crisis that collapsed the entire health system. Critical areas of HSS efforts initiated to address the six health system building blocks include, creation of an enabling environment through health sector policies reforms (e.g., National Health Policy and Plan, Human Resources for Health, Health Financing, Decentralization, HMIS, etc), rehabilitation and construction of additional service delivery points to increase access and bridge the inequality gap, improve staff motivation and retention through in-service trainings, increased incentive and performance based financing, improvement in monitoring and evaluation of the health system, and supply chain. These HSS efforts are expected to address health systems challenges and weaknesses that underpin immunization and other health care delivery services.  Below are specific areas of HSS efforts:   |  |  | | --- | --- | | **Building block** | **Current HSS Efforts** | | Health services | In 2011, the Ministry of Health and Social Welfare along with her major stakeholders elaborated a ten year plan and an Essential Package of Health Services (EPHS) with a vision of a healthy population with social protection for all and a goal to improve the health status of the population on an equitable basis.  To improve maternal and child health conditions, the primary health approach was identified as the way forward. Also, to address few of the health services constraints that are related to limited access to service delivery, especially immunization, the current plan calls for network of service delivery points, constructions of over 500 service delivery points in hard– to-reach and under serve areas in the next 10 years and the use of community outreach services.  The community health service program is being strengthened through support from GAVI, UNICEF, USAID, and other partners to buttress efforts of the health facilities especially in the areas of promotive health, water and sanitation and home based management of the five major childhood diseases. Community health volunteers are trained to provide home based management of fever, malaria, diarrhoea and pneumonia including other health conditions.  Under the performance based health financing arrangements supported by the pool fund, USAID and European Union NGOs and County health teams are providing services at both the facility and community levels to bridge the inequality gap, improve health care delivery quality and coverage. | | Health workforce | HR has been identified has a critical component of the health system in Liberia, due to inadequate and less motivated skilled and professional workforce.ANational Human Resources for Health Policy and strategy was developed with support from donors and partners including GAVI, to improve production, retention, motivation and deployment. The HR Policy overarching goal is for facilities and institutions to be managed effectively and efficiently and equipped with the right skills mix of qualified workers who will provide quality services that meet the highest professional and ethical standards and sector’s needs. In accordance with the NHSWPP, the principles guiding this human resources policy are equity, efficiency, quality, sustainability, decentralization and partnership.  As Liberia continues to strengthen its health systems, a key component of rebuilding include improving the human resources for health (HRH) situation. The number of operational health training institutions (9) in Liberia are limited, which implies scaling up the stock of HRH is require through expansion of capacities of current institutions, establishment of new training infrastructure, reliance on foreign training institutions, or reliance on immigration of previously trained international HRH and community health volunteers to meet health workforce goals.  To increase the production of the health work force, the Government has made medical education free with a minimum monthly stipend for students and an expansion of the medical school facility to increase enrolment through funding from the Italian Government and the World Bank. The world bank project also provided monthly salaries for lecturers in critical areas of needs.  Most of the paramedical institutions are also free, with support from the McCall Mac Bain Foundation, UNICEF and the Government to increase the number of nurses and midwives. In addition to these initiatives, the US Government renovated the Tubman National Institute for Medical Art (TNIMA) to increase production and provided TA through the RBHS project review the pre-service curriculum. USAID also supported the Esther Bacon School of Nursing  in Zorzor in to TNIMA and  Housing for health workers are current being constructed in many parts of the country to ease the problem of accommodation for rural health workers while performance based financing contracts have been awarded to both NGOs and two county health teams to improve staff performance and community health workers incentives through health service delivery performance.  External and local scholarships are provided by the Government through bilateral arrangements and budgetary support, WHO, EU, and the USAID to enhance the capacity of the Ministry. | | Health Information | *The national health policy asserted that HMIS will be strengthened in order to better collect, organize and maintain relevant data in a timely fashion. The system will have the capacity to produce reports related to health sector development, including the analysis of trends, in order to understand the evolution of the health sector over time.* In response to this policy statement, the Ministry embarked on a vigorous campaign to improve health information system through capacity development and policy formulation. First, HMIS Unit was made functional by staff recruitment and training at central and county levels through support from Global Fund and GAVI. Second, ICT equipment worth close to a million United States dollars were procured and distributed at national and county levels through the World Bank Health System Reconstruction Project (HSRP) and GAVI. Third, there was a major revision of multiple, fragmented and uncoordinated reporting tools to a harmonized instrument and coordinated reporting procedures. USAID through RBHS provide technical assistance for the harmonization of reporting instrument and the formulation of the HMIS policy and Strategy. Fourth, the elaboration and promulgation of a HMIS policy and strategy in 2009, provides a boost to data generation, analysis and dissemination for an evidence-based planning and policy decision making.  The current HMIS evolved from the use of calculators and typewriters (no computer, printer, vehicle, etc), to the use of modern ICT equipment (at least 2 computers per county, laptops, servers, printers, etc), erratic monthly health facility reporting to over 70% (386 out of 551) average consistent monthly reporting and variant reporting software (MS Excel, Access) to a standard reporting and analysis software (District Health Information System). Trainings in the use of the DHIS were funded by GAVI HSS, USAID, and Global Fund. In addition, county level monthly reporting has transformed from paper-based to electronic reporting. This substantial progress has translated into gradual improvement in the Ministry’s Annual Reports of 2007, 2008 and 2009, and assessment of fewer health programs (Immunization, HIV/AIDS, Malaria and Tuberculosis). | | Medical products, vaccines & technologies | Over 70% of medical products procured and consumed by the public health facilities are provided by donors and partners (e.g., Global Fund, USAID, UNFPA, NGOs, etc). There is an essential drug list and draft drug policy developed by the Ministry and a drug regulatory authority that has the mandate to regulate the pharmaceutical trade in Liberia.  The Government of Liberia receives ample provision of new and under used vaccines and its related injection materials from GAVI, while the traditional vaccines and vaccines related supplies are procured by the Government.  The Ministry through support from Global has constructed regional warehouses, deployed regional and county pharmacists and procured supply chain vehicles for each county to ameliorate the acute shortage of vaccines, drugs and medical products.  A 10-year Supply Chain Master Plan was developed through TA and financial support from USAID, Global Fund and GAVI. The master plan objectives include tracking of medical supplies, improving pharmaceutical products reporting, rationale use of drugs and reduction drug stock out. | | Health Financing | Financing the health sector is a critical input that requires National Government and donors full commitments. Therefore, to maximize the resources available from all sources, a financing policy was formulated that establishes a mixed approach to mobilizing resources that includes a sustainable level of government financing, more efficient use of donor support and potential alternative financing mechanisms. The GOL is committed to doing its part by progressively increasing the share of the national budget that goes to the health and social welfare sector.  The 2007 National Health Policy commits the Government of Liberia to financing health care at the highest level possible, taking into consideration its revenues and competing priorities. The policy commits the government to progressively increasing the share of its budget apportioned to the health sector, while a mixture of other financing strategies (e.g., user fees, health insurance, and other forms of pre-payment) will also be explored. However, the policy states that “In light of crushing levels of poverty, the Ministry has decided to suspend the administration of user fees at the primary health care level until (2013) the socio-economic situation improves and financial management systems perform to a level that ensures the proper extraction, accounting and utilization of revenues.”  The Health Sector Pool Fund was established by the Ministry of Health and Social in 2008 to help finance unfunded priorities from the National Health Plan, to increase the leadership of the MOHSW in allocating resources, and to reduce the transaction costs associated with managing multiple different donor funds. As of June 30, 2010, the pool fund had four contributing donors. Total commitments to the pool fund exceeded US$ 35 million, while over US$ 20 million had been received and spent. Over two-thirds of all commitments to the pool fund has been allocated to directly funding service delivery at government facilities, thus contributing continuity of service delivery during the transition from relief to development. By 2008, contracting of NGO and County Health System were chosen as the main strategy to organize healthcare provision. With NGOs and FBOs continuing to be the main service providers, they were therefore well placed to assume a formally regulated role.  The MoHSW has institutionalized the conduct of National Health Accounts (NHA) and has conducted two NHAs in five years (NHA 2009 and 2011) to streamline the information on health financing at various levels for health provision such as financial allocation and budgetary performances. This will provide that evidence for planning and management of financial resources.  DFID supported the establishment of the health sector pool fund and office of financial management while other partners including USAID through RBHS provided capacity building trainings for financial managers at both central and county levels. | | Leadership & Governance | The Ministry has developed a ten year plan (2011 – 2021) along with subsector policies and strategies to guide the provision of health services.  The Liberia medical and dental council and other professional boards (nursing and midwifery, pharmacy, etc) have been strengthened to promote quality and adherence to ethical issues, including clinical standards. To buttress these efforts there is an annual quality assurance assessment and accreditation surveys that are conducted to appraise public and private service providers.  A leadership and management capacity assessment was conducted at both national and county that identified capacity weaknesses at these levels. To enhanced leaders and managers capacity at the policy and operational levels, the Ministry designed a leadership and management course with the Mother Patern College of Health Services and Yale University in the US to strengthened central and county level capacities.  The Government of Liberia (GOL) has embarked on an ambitious process of decentralization, with a short to medium-term goal of health sector de-concentration of authorities to County Health and Social Welfare Teams (CHSWTs) and a long-term goal of devolving authority over several fiscal and administrative responsibilities directly to County Administrations. Guided by the Liberia National Policy on Decentralization and Local Governance, the National Health and Social Welfare Policy and Strategic Plan (2100-2021), the Public Sector Reform Statement (2010) and with external technical and financial assistance from the European Union and the World Bank, the GOL is currently undertaking a number of relevant activities that will represent the skeleton of the decentralization process. | |
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| **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.*  The goal of the National Health Policy and Plan is to improve the health and social welfare status of the population of Liberia on an equitable basis. The policy objectives include; 1). increasing access to and utilization of a comprehensive package of quality health and social welfare services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems; and 2). making health and social welfare services more responsive to people’s needs, demands and expectations by transferring management and decision-making to lower administration levels, thereby ensuring a fair degree of equity.  The HSS objectives although consistent with the National Health Plan it is intended to address specific constraints related to immunisation as identified in the Country Multi Year Plan (cMYP) and the health sector situation analysis. Although there are current health systems strengthening efforts as indicated in previous sections (2.2 and 2.3), these initiatives are not immunization focus to a large extend and are centred on the six HSS building blocks. The development of the HSS objectives under the GAVI proposal considered critical areas that will contribute and ensure the strengthening of health systems in support of immunization services.  ***Objective 1:* Increase access and utilization of Essential Package of Health Services (EPHS)**  This objective addresses the HSS challenges identified in the health services and human resources for health building blocks that contributed to low immunization coverage. The proposal earmarked three service delivery areas (SDA) with 13 key activities that will increase access to the EPHS. Service delivery area one include: 1) the establishment of a central biomedical technology workshop and 2 regional workshops to address the maintenance and repairs of cold chain and other medical equipment; 2). Procurement of 100 motorcycles to facilitate integrated outreach; and 3). Payment of monthly performance based incentives to service providers for achieving key MCH indicators (e.g., Penta 3 coverage, institutional delivery, drop-out rate, etc). The second service delivery area includes community health interventions and the third is focused on quality assurance.  The intend of this objective is to reduce health system bottle necks identified in the HSS building blocks that are depriving many Liberian children of immunization and other related health services. By establishing biomedical technology workshops, the frequent breakdown of medical equipment especially cold chain equipment will reduced and vaccines will be kept safe and available. Performance based financing arrangements with both private and public providers will not only increase access and coverage of immunization but will also strengthened public-private partnership. Counties (e.g., Sinoe, Montserrado and Grand Kru) with the lowest immunization coverage (e.g., Penta-3 coverage ranging from 50.2% to 64.4%) in 2010 and with no performance based financing (PBF) arrangement will be contracted to provide PBF services.  In addition to the performance based financing, community health volunteers will be trained in Reach Every District (RED) and Reach Every Pregnant woman (REP) strategies to facilitate attainment of the desire immunization coverage. Also, community health volunteers will be provided with identification materials which will serve as motivation and recognization.  **Objective 2: Strengthening and making operational a well coordinated M&E and HMIS**  The purpose of this objective is to address systematic weaknesses associated with monitoring, evaluation and health management information. Eleven major activities have been listed in service delivery area 2.1 as strategies for improving health system monitoring, evaluation and research. Activities identified include, the conduct of regular quarterly supportive supervision, training of county level staff in data analysis and reporting, conduct of EPI cluster surveys, reproduction health facility reporting tools (e.g., ANC, delivery, immunization, etc, registers) and data quality assurance exercises. These activities are expected to provide the required evidences for planning, resource allocation and prompt decision making. To assess the immunization program, an effective surveillance system and monitoring are crucial. Besides, immunization services tracking and data quality are very important for assessing and evaluating health system performance. Monitoring of the MDGs as we approach 2015 require adequate and effective monitoring of the health system, including the conduct of programmatic research into health system challenges for prompt interventions to facilitate the attainment of the MDGs, particularly Goals 4, 5 and 6.  **Objective 3: Strengthen financial management System**  This objective is intended to address financial issues related to transparency, financial reporting, planning and budgeting. Financial transparency and accountability of resources are crucial for external and local resource mobilization and trust. Under this objective, three activities have been identified; the conduct of annual financial audits, annual financial assessments and accountants at the central and county levels. Implementations of these earmarked activities are expected to improve financial reporting, accountability and credibility.  **Objective 4: Enhance MOHSW logistical, human resource and technical capacity**  Limited skilled health workers and inadequate logistics have impeded immunization service delivery. To address these constraints, two service delivery areas were identified with strategies to increase vaccines uptake and strengthen the entire health system. The procurement of motorcycles, vehicles, vaccines carriers, refrigerators, solar panels, construction of national and regional dry stores will improve vaccine management and availability of drugs and medical supplies at the central, regional and county levels. |
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| * 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.  **Goal:** In consonance with the Liberian 10-Year National Health Policy and Plan, the goal of these activities outlined in this proposal is to improve the health and social welfare status of the population of Liberia on an equitable basis.  **Objective 1: Increase access and utilization of Essential Package of Health Services (EPHS)**  Increasing access to EPHS which include immunization services, through immunization outreach and defaulter tracing, hiring of additional vaccinators in poorly performing counties and the inclusion of the private sector will compliment current effort to reduce infant and child mortality. The involvement of community health volunteers is also relevant to improving immunization services.  The MOHSW will establish a multi-pronged approach to improving and assuring quality of service provision at all levels. In order to improve quality of health care services, the Ministry will conduct annual QA assessments at the facility level and provision of infection control equipment among others. This will entail visiting designated facilities and providing feedback to staff on how to improve services, conduct clinical audit in hospitals and train clinical staff in infection control systems in line with SOP.  **SDA 1.1** **Essential Package of Health Services (EPHS)**   * + 1. Establish biomedical technology workshops at central and regional levels     2. Procure 100 motorbikes for integrated outreach services     3. Provide performance based incentives for essential MCH (e.g., Immunization, Deliveries, FP, etc) interventions in 50 private facilities     4. Provide monthly performance based incentives to 75 health facilities not cover under current performance based financing arrangement     5. Re-produce 50,000 home based cards and 50,000 Road to health cards     6. Re-produce 75,000 TT cards     7. Train 4 Paediatricians   **SDA 1.2 Community Health Services**   * + 1. Re- produce visibility and identification materials (e.g., CHV badge, Jacket and bag ) for 1,450 CHVs     2. Train 1,450 CHVs in RED and REP strategies   **SDA 1.3 Quality Assurance**   * + 1. Procure equipment and supplies for implementing infection and control     2. Conduct annual clinical audits in 28 hospitals nationwide     3. Train 1,000 clinical staff in infection prevention and control systems in line with SOP     4. Conduct annual quality assurance and health facilities accreditation assessments in all health facilities   **Objective 2: To strengthen and operationalized a well coordinated M&E, Research and Health Information System**  Monitoring and evaluation of the health systems play an integral part in ensuring that all immunization related activities are carried out according to plan and that the progress can be tracked.  It is important to undertake regular supportive supervision at the county and health facility levels to mentor staff, motivate and ensure that policies and SOPs are followed. The below listed activities in this section will address few of the health system challenges identified in the health system building blocks section 2.2 of this proposal. Implementation of these activities will not only improve the health sector surveillance system, data quality, review of the system performance but will provide the needed evidence for informed decisions making and interventions that will shape the immunization program for better results.  **SDA 2.1 Health System Monitoring, Evaluation and Research**   * + 1. Undertake quarterly supportive supervision     2. Conduct refresher trainings for 50 M&E and 75 County Health Team staff in M&E and Research     3. Conduct EPI Cluster surveys     4. Conduct quarterly on-site data verification and validation     5. Conduct semi -annual programs reviews     6. Conduct review of Essential Package of Health Services 3yrs of implementations     7. Conduct annual data quality audit (DQA) in compliance with national guidelines.     8. Finalize, print and disseminate research agenda and guidelines     9. Re-produce registers (e.g., ANC, Deliveries, PNC, etc) for all health facilities     10. Train 1,000 health workers in data analysis and reporting     11. Contribute to annual health conference   **Objective 3: To strengthen financial management system**  The contribution of this objective to immunization program and the overall national goal is to maximize the available limited resources, to institute financial accountability and transparency that will ensure financial sustainability and gains made over the years. The training of financial managers will ensure that funds are use for the intended and that financial allocations are made to influence health outcomes.   * 1. **Financial Management**      1. Conduct refresher trainings on planning, budgeting and financial management for 100 County Accountants and Administrators      2. Undertake annual financial assessments to the 15 counties      3. Conduct annual GAVI financial audits     **Objective 4: Enhance MOHSW logistical, human resource and technical capacity**  Increasing the technical capacity of workers in the Liberian health and social welfare sector is a high priority for the MOHSW. To ensure sustainability of the improvements to the health system, the plan focuses on developing, motivating, retaining and providing the require logistics for human resources performance. To address the identified health systems challenges related to immunization coverage, provision of computers for reporting, vehicles and motorcycles for data collection, verification and audits are important. The monthly incentive payment of central level EPI staff that are not on Government Payroll and the training of internal auditors to ensure adherence to financial regulations is necessary. These earmarked activities will contribute the overall health system performance.   * 1. **Human Resources and Technical Capacity**      1. Conduct training 75 health facility managers on PBC concept and SOPs      2. Recruit TA for health system strengthening      3. Procure 32 desktop computers, 32 laptops, 32 printers and 5 photocopier for county and central level reporting      4. Procure 8 vehicles for central level monitoring and supervision      5. Procure 15 motorcycles for county level M&E      6. Conduct regular maintenance and repairs of vehicles   **4.2 Logistics**  The activities under the logistics SDA centred on the purchasing of communication and transportation items, refrigerators and solar panel are crucial for the implementation of all health services including immunizations.  In order to ensure vaccine delivery to all counties the proposal includes the procurement of refrigerated trucks as well as the construction of cold storage unit at national and 2 regional depots, in Bong and Grand Gedeh counties. These activities will minimize vaccine stock out and improve supply chain in the country.     * + 1. Procure 20 high frequency base radios for selected hard to reach health facilities     2. Procure 20 solar panels for selected hard to reach health facilities     3. Procure 15 vehicles for county outreach services and supervision     4. Procure 2 refrigerated trucks for vaccine distribution     5. Procure 10 solar refrigerators for private health providers     6. Procure 150 vaccines cold boxes for both private and public health providers     7. Construct Dry store at national level     8. Construct 2 regional Cold stores for vaccine management   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.*  The use of the Reach Every District (RED) strategy recommended by WHO to immunization coverage was adapted by Liberia in 2010 to accelerate immunization interventions. This strategy have shown to be one of the effective immunisation strategies of reaching unvaccinated children especially in hard to reach rural areas, marginalised and under serve communities. In addition to the RED approach, community health program have proven to be effective in addressing maternal and child health conditions.  Since 2004, immunization coverage continues to increase. DPT3/Penta 3 coverage increased from 27% in 2004 to 73% in 2010 (MOHSW 2010 Annual Report). This gradual improvement in immunization coverage is due to government’s commitment to the health sector and enormous technical and financial support from partners especially GAVI, UNICEF, WHO and USAID.  *Lessons learned from Bomi decentralization project for building capacity at the CHSWT management level:*   * training accountants to strengthen procurement and financial services * need for experienced accounts, logisticians and procurement officers * evidence that guidelines/SOPs improve health care quality * evidence that supportive supervision improves quality of health services * evidence that PBF improve health outcomes   Lessons learned from GAVI HSS implementation include;   * Participatory proposal development process that is aligned with NHP, contributes to a successful implementation. * Low institutional capacity limits implementation * Strong and committed leadership improves coordination and partnership |
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| * 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.*  Activities recommended in this proposal to address health system bottle necks will ultimately benefit children under-fives years of age in consideration of gender, equity and vulnerable groups in hard to reach areas. In addition, targeted service providers will benefit from enhanced capacity through in services training, motivation by monthly incentive payment and conducive environment by provision of logistics to work with.  The nine SDAs promote geographic equity by aiming to increase the capacity of actors at both the county and facility levels. In fact, across the board the focus of the proposal is to support the decentralization effort to build skills and shift resources to the county level in order to better reach all Liberians. By establishing SOPs and ensuring that quality health services are being provided through assessments and supportive supervision, the MOHSW will work to ensure that improvements extend to all levels of service delivery. Additionally, research priorities will include the execution of studies to document care-seeking behaviours and immunization uptake to identify and address roadblocks to access. This initiative paired with a stronger monitoring and evaluation system at the county level will aid CHSWT members in determining weaknesses in activities at both the facility and community level. Moreover, the health sector review meetings will serve as a forum for addressing findings and adjusting strategies.  Furthermore, the bolstering of community health services through CHVs will help ensure that benefits are equally distributed to the most geographically marginalized communities. Through this proposal CHVs and CHSWTs will receive both materials and transportation that will increase the frequency and quality, through in-service supervision, of their visits to hard to reach areas. The proposal seeks to support CHVs in carrying out their tasks by providing materials and identification documents, which intend to increase their visibility and credibility in the communities they serve. While the CHSWT, at both the county and facility level, will have access to transport crucial for conducting supervision and in-service training of CHVs.  The purchased of refrigerators trucks and construction of dry cold stores at national and county levels with not only benefit children but the entire population.  Objective 1, which is to increase access and utilization of Essential Package of Health Services (EPHS) will benefit the entire population but most especially women and children. This is because most of the earmarked activities immunization related.  Objective 2, calls for strengthening and operationalizing a well coordinated M&E, Research and Health Information System. The main beneficiary of this objective are national and county level staff that are involve with data collection, reporting and research but indirectly, women and children will benefit from decisions and interventions emulating from research findings and data analysis.  Financial managers and supervisors are the direct beneficiary of objective 3, which is to strengthen procurement and financial management systems.  Objective 4, will mostly benefit children of immunization age because most of the activities recommended for financing are EPI related (e.g., procurement of refrigerators trucks, vaccine carriers, solar panel, etc). |
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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.*  Currently the ministry is revisiting the National Monitoring and Evaluation Policy and Strategy to accommodate the goals and set of indicators established by newly developed ten-year health and social welfare policy and plan. The M&E policy and strategy shall be the ministry tool to monitor the overall performance of the health and social welfare sector and the impact of development initiatives through analysis of routine information, surveillance data, reviews and periodic survey and population based surveys. Through capacity building and support from HSS and other support, the ministry is aiming at becoming more results oriented through strengthening its evidence-building capacities.  The National Health Management Information System (HMIS) is an integral part of the Ministry’s M&E and Research Division. The HMIS will collect data in ways that will allow stakeholders to study how resources are allocated across levels of care, between central and peripheral administrative bodies, between urban and rural areas and across counties. This will encourage an informed policy discussion about equity, of various sub-systems specially designed for data collection, processing and reporting.  As part of its M&E culture, the MOHSW and key stakeholders will continue to carry out period and annual reviews to assess the implementation of the National Health and Social Welfare Plan, to identify operational best practices and lessons learned and to prepare work.  The indicators included in the Performance Framework were derived from the National Health and Social Welfare plan. Please see attached copy of the NHWPP.  The data collection strategy for the routine data (known as *national essential indicators and dataset* or shortly as NEIDS*, including all GFATM, HSS, and PBC* data needs has been established at community, facility and county level through the electronic medium of the DHIS (District Health Information System). All data for **Health System Strengthening** output indicators are collected through the routine DHIS facility based reports. Data on human resources training, supply chain are currently collected directly by the respective national Programs and Units of MOH/SW. However, the ministry has recently developed the subsets of HMIS such Human Resource Information system (including pre- and in service training data base), Logistics and Supply Chain information Management Systems. The MOH/SW health information system is a coordinated system that is used by all implementing partners for data collection from the community, health facility (public, private, NGOs, etc), district and county to the national levels. Data are collected on a monthly basis, complied at county level (sub-national administrative areas) and sent to central MOH/SW data repository. To ensure accurate, comprehensive and timely reporting, the HMIS has recently been upgraded to DHIS-2 and a comprehensive DHIS training in all 15 counties and health facilities has been rolled out. There is still need for more training and M&E and Research Division of MOHSW will coordinate future capacity building and trainings, especially in the areas of data collection, analysis, interpretation and production of information products at county and district levels.  **Community-based data and indicators:** Community based activities and indicators are currently not captured into the newly developed DHIS. Partners and facilities implementing community based activities are required to report directly to relevant department within ministry of health. There are considerations to set up subset database or integrate the community and non-health facility based data and information with the HMIS. Community based data collection tools (forms, registers) have already been developed by the ministry and its partners.  Data flow:  The diagram below presents the reporting linkages and established data flow procedures – from the community to health facilities through CHTs to Central MOH/SW. For HSS reporting requirements, MOH/SW will utilize current national M&E reporting procedures.  PR 2(Plan)  PCT/MOH&SW  Health facilities  County Health Teams (CHTs)  M&E AND RESEARCH/  HMIS  GOL  National & County level: NGOs, NDS/Supply Chain, National Programs (eg NMCP), Ministries and institutions  Donors & Partners  District Health Officer (DHO)  comm/ CHVs  5th day of subsequent month  15th day of subsequent month  Private pharmacies / medical store/clinic  SR (and or CHT)  National Programs/SCMU  Various mechanisms and support systems have been introduced by MOH/SW and its partners to improve data flow and avoid late reporting: 1) use of automated DHIS reporting tools 2) training of CHTs and HFs on DHIS and new reporting forms and registers. 3) Improved supervision, monitoring and mentoring to address issues related data collection and reporting 5) logistical support (computer, printers, motorbikes, vehicles, electricity supply) and 6) coordination mechanisms (TWG, joint meeting) with NGOs, private facilities and transport. Plans are underway to introduce a web portal data collection.  Despite these measures and systems strengthening there are still challenges that are causing delays in getting complete and timely reports from health facilities. Major factors contributing to these challenges include bad road network, broken bridges and ill equipped infrastructures, etc,. Given the length rainy season (6 months), the bad road condition and broken bridges, causes frequent breakdown of motorbikes and vehicles. Also, feedback channels are still weak within the MOH/SW and partners systems. For the HSS and GFATM programmes, the ministry uses mailing system and joint reviews as feedback channels.  4.2 b) Strengthening M&E systems  *→ Please describe the M&E systems strengthening activities to be funded through this proposal.*  The activities outlined in this GAVI proposal under M&E are support functions that will facilitate and enhance the smooth implementation of child health interventions including Immunization. Data collection, management and reporting are essential in the overall scheme of monitoring and evaluation. In this regards the conduct of annual data quality audits are being proposed as a means of improving the quality of data. Similarly, in the ensuring three years HMIS registers will be printed for all health facilities in the country.  As part of M&E activities, a number of review mechanisms are being proposed at all levels of the health sector. Quarterly health sector review meetings are envisaged at the county level. During said meetings the county health and social welfare teams (CHSWT) along with the partners will review progress towards achieving targets as outlined in the NHSWPP and the GAVI HSS Proposal. Additionally, joint health and social welfare reviews will be conducted for the communities and the health facilities. At the national level, annual reviews of the National Health and Social Welfare Policy and Plan will be carried out. This will be supplemented in 2014 by an external, independent evaluation/review of the progress of implementation of the national strategy.  Routine monitoring, data quality checks and verification and the review of programs implementation are being carried out with a focus on child health. This is evident by the inclusion of immunization indicators in the national core indicators listing and the Performance-based Financing validation scheme. The performance of implementing partners and CHTs that are contracted-in for the delivery of health services will be assessed through quarterly on-site verification and validation of data.  The 10-year National Policy and Plan suggests that the Ministry of Health and Social Welfare will promote a culture of inquiry into best practices to improve the delivery of essential health and social welfare services. As a result, research will provide evidence of the most effective and efficient mode for the delivery of services. The strengthening of capacities at both the central and county levels for the management and conduct of research will be an activity in the proposal. For the purpose of the submission, assessments being proposed include annual health facility accreditation that categorizes health facilities in order of readiness and capacity to implement the EPHS; the conduct of an EPI and other health related coverage surveys; and a study on care seeking behaviour and the uptake of immunization services. |
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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).*  The financing plan of the National Health and Social Welfare Plan identifies funding sources to implement the plan but firm commitments have not being received. It is assumed that funding will come from a number of primary sources (see attached National Health and Social Welfare Plan and 2-year Operational Plan). The sources of funds identified are:  1) The Government of Liberia budget;  2) Special budgets for National Vertical Programs (e.g., Global Fund);  3) Bilateral/Multilateral funding; and  4) Other funding sources (e.g. GAVI, World Bank, partners, etc)  The National Health Plan (2011-2021) cost projection is conservative, based on a number of assumptions and calculated only for the public network, composed of government and selected non-for-private facilities, indicates that expenditure per head (at 2011 prices) will increase from US$ 18 to US$ 29 over the period. However, if a conservative 5% annual inflation rate is applied (the result being the actual money necessary every year) expenditure per capita grows to reach US$ 44 in 2021. (See attached National Health Plan).  Also, according to the information collected during the elaboration of the resource envelope, the funds available for the fiscal year ending in June 2012 add up to US$ 140.7 million (Table 1), or US$ 37 per inhabitant. Funds projected for the next fiscal year reflect the present uncertainty; only three donors were able to provide relatively hard commitments, amounting to US$ 54 million.  Table 1. Projected Resource Availability. 2011/2013    Source: donor agencies and OFM  Less than 1/3 of the total projected funding corresponds to domestic sources. USAID is the biggest donor and also the most important source of funding. The aggregate Global Fund contributions sum up to US$ 29 million, or almost a quarter of the total.  **1. The Government of Liberia Budget (see National Health and Social Welfare Plan 2011 – 2021).**    It is anticipated that funding for the MOHSW from the national budget will provide 1/3 of the total funding required for the ten-year National Health Plan, i.e., the equivalent of 140 million USD. This estimated revenue is based on the following assumptions:   * That the current budget of the MOHSW is approximately 27 Million USD (including funding for JFK hospital) which represents 7.7% of the total national budget of 350 million. * That the national budget will grow yearly by a factor or 20% resulting in a budget of 700 million in 2021. * That the MOHSW share of the national budget will increase from 7.7% in the 2011 (July 2011-June 2012) by 1% in subsequent budgets. * Based on these assumptions, the MOHSW contribution to the National Health Plan would be 129 Million in 2021. * The per capital contribution would increase from $18 in year 1 (2012) to $29 in 2021(NHP estimate).   **2. National Programs**  There are four major national programs that are already receiving significant yearly funding, i.e., EPI, Malaria, TB and HIV/AIDS. In addition there is a more modest funding level provided annually for other programs, e.g., River Blindness and leprosy. The funding of these programs should be considered as a contribution to the National Plan, especially since some key components of the EPHS are funded by these programs, e.g., immunizations. However, to include them properly, more information will be needed about their yearly funding levels to identify their contribution to the overall health sector.  **3. Bilateral/Multilateral Funding**  The financing of bilateral and multilateral funding for both humanitarian and developmental programs is taken into consideration. While the figures currently included in the table are illustrative, they do indicate an anticipated, i.e., that humanitarian funding will be phased out by the end of 2011, and the developmental funding needs to be phased in as soon as possible. In addition, current Global Fund support for Malaria and TB programs is uncertain.  4. **Other Sources of Funding**  There are other sources of funding for the Liberian health sector. Faith based organizations currently manage close to 50 health facilities, including a number of county hospitals, under the auspices of the Christian Health Association of Liberia (CHAL). This and other contributions should be factored into the financing of the health sector. In line with the National Health and Social Welfare Plan financing GAVI funds for HSS support will fall under other sources of funding. |
| 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*   Fourteen years of devastating civil war completely ruin the Liberian economy resulting to a large extend in its near collapse. The productive sector of the economy though steadily improving, is yet to fully recover, thereby generating a sustained level of income (revenue) and an appreciable level of increase in GDP. This situation has placed severe budgetary constraints on the government resulting in its inability to adequately respond and address the enormity of competing demands of the economy.  Government’s current budgetary contribution to the health and social welfare sector is estimated at 7.7% (FY 2010/11), this is far too meager to address the multiple and enormous challenges of the sector. Additionally, this situation is considered a major contributing factor for the country not meeting the Abuja target of 15% of its GDP to the health sector.  While funding from external sources have and continue to play critical role in addressing the challenges of the sector, there still remain a serious funding gap. This has given rise for the sourcing of additional fund to bridge the funding gap. The availability of such additional fund will address serious challenges in selected critical areas; service delivery, systemic components (support systems) and coordination and partnership. It is for these reasons that the availability of GAVI HSS funding is indeed timely and a necessary imperative. GAVI HSS funding will no doubt contribute immensely in complimenting governments’ efforts in reducing the currently disease burden and the attainment of the MDGs.  Although the proposed GAVI HSS support for the given interventions is fixed in the costing and financing of the National Health and Social Welfare Plan, the GAVI HSS support will be specifically used for the following selected activities as costed in the attached budget and work plan.  The HSS budget was developed for a three year period with 4 key objectives, 7 service delivery areas and 49 major activities. Procurement of equipment and logistics accounts for 27.4% of the total budget. Other major budget areas include supervision, monitoring, evaluation and research 13.1%, training 8%, technical assistant 2% and infrastructure 5%. Direct immunization support cost is approximately 22% which is spread over the different service delivery areas (e.g., logistics, research, EPHS, etc).  The Ministry of Health is committed to effective and efficient resource utilization as indicated in the Policy and Plan. Activities earmarked in this project will expand the delivery of health services, contribute to high immunization uptake and improve the quality of existing services. |
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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:** | Ministry of Health and Social Welfare |
| **Objective(s):** | 1). Increase access and utilization of Essential Package of Health Services (EPHS)  2). Strengthen and operationalize a well coordinated M&E and Health Management Information System  3). Strengthen procurement and financial management Systems  4). Enhance MOHSW logistical, human resource and technical capacity |
| *🡪Description of the Lead Implementer’s technical, managerial and financial capabilities.*  The Ministry of Health and Social Welfare is the lead implementer of the GAVI HSS Grant. The Ministry has the require technical, managerial and financial capacities at both central and county levels to implement the grant. In addition to the available capacity within the Ministry’s structure, there are technical partners with rich expertise and experiences that are at the disposal of the Ministry to utilize. Also, additional technical assistance will be acquired to buttress Government’s efforts during the implementation of the HSS grant.  The Ministry of Health and Social Welfare has the managerial, technical and financial capacities to successfully implement the activities outlined in this proposal. | |
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| **Lead Implementer:** |  |
| **Objective(s):** | 1)  2)  3)  etc. |
| *🡪 Description of the Lead Implementer’s technical, managerial and financial capabilities.* | |
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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.* |
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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? | *🡪go to section 6.1 c) (iii) and 6.1 c) (iv)* |
| *🡪go to section 6.1 c) (ii)* |
| (ii) If no, why not? | |
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| (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. | |
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| iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, 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 the* [*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* |
| *🡪add extra rows as needed*  *To improve health service delivery* | Work with the department of health services to implement the 10-year health plan and EPHS | Ministry of Health and the indirect beneficiary is the Liberian People | 3 years | 360,000 |
| *To enhance implementation of the NHP* | Hire consultant to develop HR In-service training Plan  Recruit consultant to evaluation implementation of NHP mid-year | Ministry of Health | 3 months | 25,000  100,000 |
| (b) Describe the process used to identify the assistance needs listed in the above table.  The first technical assistance will be hired to work with the chief officer and the immunization program to ensure that the essential package of health service is implemented in all public health facilities. The TA will also work closely with the immunization program to assist in the implementation of the GAVI HSS immunization related activities. The TA is presently working in country as an expert with the Ministry but his contract funding source is unpredictable for the next three years. Therefore, the Ministry sees it expedient to contract his services.  The HR TA will be recruited through a competitive process. The procurement Unit will advertise in the local dailies for a consultancy firm or qualified candidate to provide technical guidance in the formulation of a National HR in-service Training Plan.  TA needed for the evaluation of the National Plan implementation will be hired through the Ministry’s and Government lay down procedure. Local and international billing process is require and the candidate or institution that presents the best proposal will be contracted. | | | | |
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| (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.*   GAVI HSS funds will be managed by the Ministry’s Office of Financial Management (OFM) through a commercial bank (ECOBANK Account Number: 10-6100163-12-011) where other projects and donors funds are kept. OFM has the responsibilities to ensure that fiduciary arrangements are in place to guarantee, trust, confidence, transparency and accountability of both government and donors’ monies. OFM has the required capacity to manage GAVI funds properly and effectively.  The current system and channel of request and approval will be adhered to during the implementation of the HSS proposal. At the Ministry, request for funds by an implementer (County, Department, programs, etc) will be made to the Deputy Minister who serves as the head of that requesting implementer for approval. When it is approved, it is taken to the procurement sections for scrutiny, if there are items to be purchased and then to the office of financial management for payment when the purchase is done. The department head is expected to review and ensure that the activity being requested to implement is aligned with both the department and GAVI Work Plan and the amount requested does not exceed what is available.  The procurement and internal audit Units on the other hand are to ensure that the request follows the Public Procurement regulation for business transactions (e.g., analysis of three quotations for better price and quality, availability of specifications and contracts, etc). When the request is accepted and purchase made, the procurement Unit submit the approved request for payment to the office of financial management were request are also review base on budgetary allocation.  Activities that are county specific received funds based on planned activities and budgetary allocation through their bank accounts for implementation.  Each implementer is expected to liquidate funds approved and disbursed based on the Ministry’s acceptable procedure and format. Both narrative summaries of activities implement and financial receipts are require by the end of each implementation.  Audits are usually commissioned by the Ministry or donor at the end of each project. However, to meet GAVI financial requirements, annual audits will be commissioned and reports submitted to GAVI to ensure financial transparency and accountability. Also, GAVI annual progress reports will be submitted to track progress and show financial execution. |
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| **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.*   In order to assure continuous follow-up of the trends in immunization coverage, the identified key activities will be continuously reviewed by all stakeholders through key coordination and management mechanisms of the Inter-Agency Coordinating Committee (ICC) for Immunization and the Health Sector Coordination Committees (HSCC), of which the department of planning and the chief medical officer of the Ministry of health are responsible for health interventions, human resources for health development, planning and programme reviews. The HSCC and ICC will review annual progress, endorse and propose concrete recommendations for improvements.  At the national level, intra-sectoral collaboration is promoted through the Health Sector Coordinating Committee (HSCC). Representation of the HSCC includes the Minister of health with his four deputies and advisors, heads of all health actors who would influence the quality of the health sector in Liberia and Coordinators of NGO’s and Civil Society Organizations, the private sector, and multi & bi-lateral missions with health development objectives. The HSCC is chaired by the Minister of Health and Social Welfare. It is the main coordination and decision making body in the health sector.  The ICC for immunization is the coordination and decision making body for immunizations. The Minister of Health chairs the ICC with the EPI Manager serves as secretary. The WHO, UNICEF, UN HC/RC, WB, Rotary International, USAID, EU, MOF, MICAT, MIA and MPEA are members of the ICC. Technical issues related to EPI are discussed during the Technical Co-ordination Committee (TCC) meetings called monthly by the EPI Manager and attended by major stakeholders.  In line the integrated EPHS, a technical committee for child survival has been formed to coordinate and to provide strategic directions of child survival interventions and advice the HSCC on policy issues among others, and the immunization programme falls under this committee.  At County level, the County Health Team is the management structure and is headed by the County Health and Social Welfare Officer. The CHTs are responsible for coordination of all activities at the health facility level. Once the linkage is established between the community and health facilities, the health officers at district level and community health workers will carry out essential health package activities in health facilities and communities under the supervision of the County health Officers. Resources for the integrated health package and operational support funds are channeled through the County Health Teams who takes responsibility for distribution to all health facilities. The Supervision and monitoring of the delivery of EPHS and well functioning community based health care delivery systems will be coordinated by County Health Teams, who are responsible for reporting of activities to the department of planning and chief medical officer of the MOHSW at national level with copies to responsible programme managers. The CHT will be supported by the national programme officers in monitoring and evaluation as well as supportive supervise of the interventions.  For the effective implementation of the GAVI HSS, the national monitoring and evaluation system will be used. There are established targets and agreed set of indicators identified in the proposal that will be tracked over time. |
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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** |
| **External** |  |
| 1. Unpredicted donor funding due to global financial crisis | 1. Increase equity and efficiency of resource allocation to the County Health Teams |
| 2. Political instability in neighbouring countries with consequent humanitarian crisis impacting on the health system | 1. Coordinate with partners to fill critical gaps and support the County Health Teams to cope with the humanitarian crisis |
| 3. Natural disasters causing population displacement | 3. Strengthen national capacity for epidemic preparedness and response and disaster management |
| **Internal** |  |
| 1. High demand of qualified health workforce in the rural areas/communities | 1. Increase motivation package to promote retention and attract qualified health workforce to the rural areas |
| 1. Absorptive capacity (e.g. administrative, financial, etc) to implement programs | 2. Strengthen capacity of County Health Teams in programming, budgeting, local procurement, accountability and monitoring |
| 1. Reduction in the Health Sector budget | 3. Introduce measures for resources mobilization and utilize other recovery schemes (e.g., health insurance, etc) |
| * 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.* | |
| ***Unintended consequences*** | ***Mitigating strategies*** |
| 1. High services utilization rate | 1. Integrate and strengthen community health services to reach all communities especially women and children 2. Promote health decision-making closer to the communities to ensure their active participation and ownership |
| 1. High expectation on quality and coverage of services | 1. Ensure health workers are accountable to the quality of services they deliver |
| 1. Increased workload for midwives and nurses and frequent drugs and medical supplies rupture | 1. Increase production and rational distribution of nurses and midwives 2. Streamline mechanisms for supply chain management |
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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* | ***✓*** |
| 6 | Essential Package of Health Services |  |
| 7 | Country Situation Analysis |  |
| … |  |  |
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