Senegal application for GAVI Alliance
Health System Strengthening (HSS)

An electronic version of this document is available on the GAVI Alliance website (www.gavialliance.org) and provided on CD. Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

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Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. Proposals received after that date will not be taken into consideration for that review round. GAVI will not be responsible for delays or non-delivery of applications by courier services.

All documents and appendices should be in English or French. All required information should be included in this application form. No separate application documents will be accepted by the GAVI Secretariat. The GAVI Secretariat is unable to return submitted documents and appendices to countries. Unless otherwise specified, documents may be shared with the GAVI Alliance partners, collaborators and the general public.

Please direct all enquiries to:
Dr Craig Burgess (cburgess@gavialliance.org) or representatives of a GAVI partner agency.

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Abbreviations and acronyms

To the applicant

- *Please ensure that all abbreviations and acronyms presented in the application and supporting documents are included here.*

ANSD : National Statistical and Demographic Agency
BCG : Bacillus Calmette - Guerin
CAFS : Support Unit for Health Funding
CAP : Project Support Unit
CAS : Support and Monitoring Unit
CBO : Community-based Organisation
CEFOREP : Study and Training Centre for Population Research
cMYP : Comprehensive Multi Year Plan
CNCA : National Commission for Administration Contracts
CONGAD : Consortium of Non-Governmental Organisations
DAGE : Directorate for General Administration and Infrastructure
DCMP : Central Directorate for Procurement Contracts
DEM : Directorate for Medical Equipment
DPM : Directorate for Medical Prevention
DRH : Directorate for Human Resources
DS : Directorate for Health
EDS : Demographic and Health Survey
EPI : Expanded Programme on Immunisation
FP : Family Planning
GAVI : Global Alliance for Vaccines and Immunisation
HC : Health Centre
HSS : Health System Strengthening
IACC : Inter Agency Coordinating Committee
IPM : Health Insurance Institute
JAR : Joint Annual Review
MDG : Millennium Development Goal
MEF : Ministry of the Economy and Finance
MSPM : Ministry of Health and Medical Prevention
MTSEF : Medium Term Sector Expenditure Framework
NGO : Non-Governmental Organisation
NHIS : National Health Information Service
PCIME : Integrated Care of Children Diseases
PDIS : Integrated Health Development Programme
PDDS : Departmental Health Development Plan
PNA : National Supply Pharmacy
PNC : Prenatal Consultation
PNDS : National Health Development Plan
PNT : National Tuberculosis Control Programme
PO : Operation Plan
PRA : Regional Supply Pharmacy
PRDS : Regional Health Development Plan
PRSP : Poverty Reduction Strategy Paper
PTA : Annual Work Plan
PS : Medical Outpost
RM : Medical Region
SIG : Information System for Management purposes
SNP : Nutritional and Excess Weight Surveillance
STM : Technical Maintenance Service
TOR : Terms Of Reference
UNICEF : United Nations Children's Fund
VAR : Vaccine Against Measles
WHO : World Health Organisation

EXECUTIVE SUMMARY

To the applicant

- *Please provide a summary of the proposal, including the goal and objectives of the GAVI HSS application, the main strategies/activities to be undertaken, the expected results, the duration of support and total amount of funds requested and the baseline figures and targets for the priority indicators selected.*

- *Please identify who took overall responsibility for preparing the GAVI HSS application, the role and nature of the HSCC (or equivalent), and the stakeholders participating in developing the application.*

The Senegal GAVI health system strengthening application, which is the subject matter of this document, aims to improve the use and delivery of a quality health service which includes immunisation.
This application is in keeping with the achievement of the objectives selected for the implementation of the second phase of the National Health Development Programme (PNDS, 2004-2008), the Medium Term Sector Expenditure Framework (MTSEF, 2008-2010) and the Child Survival Strategy Plan (2008-2015). Its aim is to strengthen the capacities of the health system with a view to improving the performance of maternal and infant health programmes.

The main objectives are:

1. To strengthen the skills in maternal and infant health programme management for at least 80% of students at the end of their studies in training schools by the end of 2010;

2. To strengthen the coordination, management, partnership and logistics of the country's 65 health districts by the end of 2010;

3. To ensure the monitoring and evaluation of the 65 health districts on the basis of performance contracts by the end of 2010.

To achieve these objectives, the implementation of this application will be based on the following strategic focuses:

- Improvement of the delivery, use and quality of the services;
- Strengthening of the integration of activities at operational level;
- Strengthening of the equipment maintenance system;
- Strengthening of the involvement of the communities in the implementation of health programmes;
- Improvement of the data management, monitoring and evaluation system;
- Strengthening of coordination at all levels.

With a view to implementing these strategies, the following primary activities have been identified:

- Support the inclusion of maternal and infant health programmes in the basic training of health schools;
- Equip new districts, and those in difficult or enclosed zones with material, financial and logistic means;
- Support the equipment and logistic maintenance system;
- Support the implementation of activities integration at operational level;
- Support district outsourcing with CBOs;
- Support data collection and management activities;
- Support monitoring activities in the districts.

Three main outcomes are expected relating to the various objectives selected:

1. Strengthening of agents' skills:

- ensure that programme needs are included in the studies given by training schools;
- ensure that the personnel from these schools has the necessary tools to ensure an efficient management of the health programmes, including the EPI at their level of responsibility;
- within the scope of the update of knowledge, the trainers are trained on the new guidelines of the health programmes with a view to ensuring that they are effectively included in basic training programmes.

2. Increase in the operational capacities of districts:

- the districts and in particular new districts and those situated in difficult or enclosed zones are equipped with material, logistic and financial resources to ensure that the activities are implemented correctly;
- accessibility and use of curative and preventive health services including immunisation are strengthened;
- health services, benefiting from skilled personnel and inputs in a sufficient quantity, provide curative and preventive health care services including immunisation;
- integration of activities in particular those relating to the health of the mother, newborn and child is effective;
- the communities are involved in the implementation of the activities through outsourcing with the CBOs and Associations which participate in improving the performance of health indicators including immunisation indicators;
- awareness of the population and the link between the health services and communities are developed and strengthened with a view to a greater approval and a better compliance of the population to the health programmes.

3. Strengthening of the monitoring – evaluation system of health programmes:

- quality data required for planning and decision-making is available thanks to the strengthening of health data collection, analysis and management means. To that end, emphasis is placed on the integration of hospital and programme data;
- a better profile of health indicators is drawn up with the implementation of a national database;
- the monitoring of the implementation of health activities is carried out better;
- the districts are assessed on the basis of established performance contracts;
- health personnel has the capacities and the methodological and resource tools necessary to carry out supervision activities regularly;
- the coordination between the national information system and the other programmes is improved;
- validated, reliable and consistent data is produced at all levels.

Duration of GAVI support:

GAVI support for health system strengthening in Senegal is requested for **a duration of three years** from the date of approval, in other words from 2008 to 2010.

Total amount of funds requested

The total amount of funds requested is estimated at **US $ 3,585,145** with 97% of the budget devoted to the costs of health system strengthening activities **(US $3,483,145)** and 3% to technical assistance, management and support costs **(US $ 102,000).**

The priority indicators selected for the assessment of activities are:

Indicator	Baseline value[4]	Date of baseline	Objective	Date for objective
1- *Number or proportion of districts achieving a coverage ≥ 80% for the PENTAVALENT 3*	76%	2006	80%	2010
2- *Proportion of agents leaving health schools per year and having participated in training sessions on the management of priority health programmes*	0%	N/A	80%	2010
3- *Proportion of districts having outsourced with at least 10 CBOs on an integrated health programme*	Not available	2008	100%	2010
4- *Proportion of districts having complied with the performance contract*	Not available	N/A	100%	2010
5- *Under five mortality rate (per 1,000)*	121 per thousand	2005	105 per thousand	2010

Definition of indicators:

- *Number or percentage of districts achieving a coverage ≥ 80% for the Pentavalent 3:* this is the overall annual coverage of the third dose of Pentavalent calculated from monthly district reports.

- *Percentage of agents leaving health schools per year and having participated in training sessions on the management of priority health programmes:* this is the number of agents from Health schools each year and recruited by the Ministry of Health having participated in orientation sessions on the health programmes compared with the number of targeted agents.

- *Proportion of districts having outsourced with the CBOs on an integrated health programme*: this is the percentage of districts having outsourced with at least 10 CBOs for the implementation of an integrated activities package on the health of the mother, newborn and infant.

- *Proportion of districts having complied with the performance contract*: this is the percentage of districts having achieved at least 80% of the performance indicators selected in the contracts. This indicator will be taken from the performance contract reports.

- *Under five mortality rate (per 1,000):* probability of dying between birth and the 5th birthday. This indicator will be collected during EDS surveys and MICSs.

Section 1: Application Development Process

To the applicant

In this section, please describe the process for developing the GAVI HSS application.

- *Please begin with a description of your Health Sector Coordinating Committee or equivalent (Table 1.1).*

1.1: The HSCC (or equivalent in your country)

Name of the HSCC (or its equivalent):

National Steering Committee for Health System Strengthening (CNPRSS)

The C.N.P.R.S.S. was created by ministerial service note no. 03303/MSPM/CAS/PNDS of the 8 May 2007.

Organisational Structure (for example, sub-committee, stand-alone):

This committee was created by ministerial order. It is chaired by the Secretary General of the Ministry of Health and Medical Prevention and coordinated by the Manager of the Support and Monitoring Unit of the PNDS. It includes a select technical committee chaired by the Director of Medical Prevention and responsible for developing this GAVI HSS application.

Frequency of meetings:[1] Monthly

Overall role and function:

The purpose of the committee is to monitor, review and validate proposals from the various stages of the process leading to the production of a document on health system strengthening. The process must integrate:

- The assessment of health system performance;
- The analysis of partners' intervention and their impact on the health system;
- The identification of needs with a view to strengthening the health system.

[1] Minutes from HSCC meetings relating to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting which endorsed the application. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

To the applicant

- *Next, please describe the process your country followed to develop the GAVI HSS application (Table 1.2)*

1.2: Overview of the application development process

Who coordinated and provided oversight to the application development process?

Dr Mandiaye LOUME Coordinator of the CAS/PNDS

Who led the drafting of the application and was any technical assistance provided?

Dr Papa Coumba Faye, Director of Medical Prevention

Technical assistance was provided by WHO and the French Cooperation.

Please outline the time line of activities, meetings and reviews that preceded the proposal submission.

Following the country's participation in the Sub-Regional Technical Briefing Workshop on GAVI-Health System Strengthening held in Ouagadougou from the 26 to the 28 March 2007 with a view to countries submitting applications for health system strengthening, a reporting meeting in the Cabinet was organised on the 18 April 2007 in order to ensure a better participation of the players in the process. We then requested and obtained support from GAVI for the development of the country's application.

1. Preparation Phase

This began with an order from the Minister of Health and Medical Prevention creating a national steering committee for health system strengthening. Along the same lines, a technical sub-committee backed by a national consultant was implemented to identify resource personnel, the tools necessary for documentary review and to adopt an activity schedule.

2. Design and development phase

This phase included:

1. The national launching seminar (on the 12 March 2007) which brought together all the players involved in the system in order to ensure a participation-based process and the adoption of a consensus on the HSS road map;
2. A documentary review (from the 12 to the 17 March 2007 and from the 26 to the 30 March 2007) which was able to analyse all the health system assessment documents available and listed by the technical committee. This review was also able to identify the strengths and weaknesses of the health system, the opportunities and progress accomplished since the last assessments and the needs to strengthen the system;
3. Five successive workshops (from the 12 November to the 7 December 2007) which were able to finalise and share the application with the various departments of the MSPM and technical partners (WHO and the French Cooperation).

3. Validation phase

During this phase the document was shared and the main inputs collected (on the 26 November 2007). There was also a meeting of the technical committee (on the 7 December 2007). On each occasion the objective was to verify the presentation and consistency of the document, the objectives, strategies and setting of the priority activities to be strengthened in the various areas. After each meeting, the technical committee took the amendments into account.

4. Application endorsement phase

A meeting of the Steering Committee for Health System Strengthening was organised on the 14 December 2007 to validate the application. It was chaired by the Secretary General of the Ministry of Health and Medical Prevention. During this meeting the background to HSS support, the objectives of the application, the implementation arrangements, the management mechanism of GAVI financial resources and the monitoring and evaluation system implemented were specified. The meeting brought together all the directorates and departments of the Ministry, the representatives from the other Ministries and partners (see Attendance list and minutes of meeting …).

These various phases were steered by the Coordinator of the Support and Monitoring Unit of the National Health Development Plan (CAS/PNDS).

Who was involved in reviewing the application, and what procedures were adopted?

The Directorates and national Departments of the Ministry of Health and Medical Prevention, the partners (WHO, UNICEF, PATH, the French Cooperation …) and the Civil Society (CONGAD).
The procedures were: making the technical documentation available, participation in the workshops and document sharing sessions.

Who approved and endorsed the application before submission to the GAVI Secretariat?

The National Steering Committee for Health Sector Strengthening.

To the applicant

- *Please describe overleaf the roles and responsibilities of key partners in the development of the GAVI HSS application (Table 1.3).*

Note: Please ensure that all key partners are included; the Ministry of Health; Ministry of Finance; Immunisation Program; bilateral and multilateral partners; relevant coordinating committees; NGOs and civil society; and private sector contributors. If there has been no involvement of civil society or the private sector in the development of the GAVI HSS application, please explain why below (1.4).

1.3: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Focal Point Programmes	WHO	Yes	Technical support: (1) Development of plans; (2) Monitoring and Evaluation of implementation ; (3) Development of periodic reports.
Focal Point Programmes	UNICEF	Yes	Technical support: (1) Development of plans; (2) Monitoring and Evaluation of implementation ; (3) Development of periodic reports.
Technical Advisors	PATH	No	Technical support: (1) Monitoring and Evaluation of implementation; (2) Development of periodic reports.
Focal Point Health Programmes	CONGAD	No	Implementation of community mobilisation and awareness activities; Evaluation of community-based activities.

To the applicant

- *If the HSCC wishes to make any additional comments or recommendations on the GAVI HSS application to the GAVI Secretariat and Independent Review Committee, please do so below.*
- *Please explain if there has been no involvement of civil society or the private sector, and state if they are expected to have a service delivery or advocacy role in GAVI HSS implementation.*

1.4: Additional comments on the GAVI HSS application development process

None

Section 2: Country Background Information

To the applicant

- *Please provide the most recent socio-economic and demographic information available for your country. Please specify dates and data sources. (Table 2.1).*

2.1: Current socio-demographic and economic country information

Information	Value	Information	Value
Population*	11,956,663	GNI per capita	US $ 740
Annual Birth Cohort*	466,310	Under five mortality rate	121/1000
Surviving Infants**	437,865	Infant mortality rate	61/1000
Percentage of GNI allocated to Health	2.6%	Percentage of Government expenditure on Health	10%

* Sources: Birth cohort and population NHIS 2006
Birth rate 0.039 (EDS IV) – Infant mortality rate 0.061: (EDS IV)
Natural growth of the population (2.5%): ANSD 2006
** Surviving infants = Infants surviving the first 12 months of life

To the applicant

- *Please provide a brief summary of your country's Health Sector Plan (or equivalent), including the key objectives of the plan, the key strengths and weaknesses that have been identified through health sector analyses, and the priority areas for future development (Table 2.2).*

2.2: Overview of the National Health Sector Strategic Plan

The assessment of the first phase of the PNDS (1998–2002) carried out in 2003 highlighted the progress accomplished and the new challenges to be met. The recommendations made as a result of this assessment and the findings of the various joint annual meetings (JAM) show that it is important to consolidate achievements and to develop new initiatives which are more oriented towards the achievement of international development objectives (IDO) in line with the poverty reduction strategy paper (PRSP).
This is why it was decided to build the second phase of the PNDS on innovations to the strategic guidelines plan, in particular by placing emphasis on the further development of decentralisation.

Global strategy of phase II of the PNDS (2004 – 2008):

The strategies selected to implement the second phase are guided by the desire to consolidate the achievements of the first phase of the PNDS and to promote prevention in an institutional environment which gives more responsibilities and more capacities at peripheral level and which places emphasis on the performance of the system. Particular emphasis will be placed on decentralisation and in particular the creation of management committees while at the same time ensuring that the capacities of local authorities are strengthened to enable them to be able to take on the responsibilities that are transferred to them. These strategies are in line with those stipulated in the poverty reduction strategy document (PRSD) and with those that should enable the Millennium Development Goals (MDGs) to be achieved. The second phase of the PNDS is presented as a medium term expenditure framework to achieve the objectives set in terms of the

reduction of the burden of maternal and infant morbidity and mortality by placing particular emphasis on the vulnerable groups. The objectives of the PRSD are: (i) to improve the access of poor people to quality social services (CPC, modernisation of the technical facilities of referral structures, development of the referral/cross-referral system); (ii) promote prevention; (iii) develop behaviour change communication; (iv) ensure basic hygiene and sanitation; (v) strengthen immunisation; (vi) develop the prophylaxis of endemic diseases, framing perfectly with the strategies of phase II of the PNDS.

Strategic objectives of phase II of the PNDS:

There are seven (7) strategic objectives selected for implementing the second phase of the PNDS:

- improve vulnerable groups' access to quality health care services;
- strengthen prevention and develop behaviour change communication;
- improve the availability, quality and performance of health personnel;
- improve the institutional capacities of the sector;
- promote partnerships;
- strengthen the monitoring and evaluation of performance;
- improve the health financing mechanisms.

The priority focus areas of the PNDS are:

- human resources;
- system strengthening;
- promotion of prevention;
- improvement of poor people's access to quality health care;
- strengthening and integration of priority health programmes.

*The main lines of action of the PNDS Phase II***:**

- improvement of the availability, quality and performance of health personnel;
- improvement of the institutional capacities of the sector;
- promotion of partnerships;
- strengthening of the monitoring and evaluation of performance;
- improvement of health financing mechanisms.

The medium term sector expenditure framework is a strategic plan which completes the PNDS. It is based on the following priority areas:

- medical prevention with immunisation, individual and collective hygiene, behaviour change communication;
- reproductive health based on: risk-free maternity, family planning and adolescents' health;
- the fight against diseases which concerns priority endemic diseases including malaria and tuberculosis but also PCIME;
- the fight against HIV/AIDS;
- the nutrition programme with the integrated nutrition package;
- the institutional support programme including cross-cutting activities such as reform, the information system for management purposes, the components of the hospital reform, drugs and pharmacy, health funding …

The main objectives of this plan are:

- to improve the availability, motivation and performance of personnel;
- to improve poor people's and vulnerable groups' access to quality health care services;
- to improve the institutional capacities of the sector by placing emphasis on the districts;
- to improve the health funding mechanisms;
- to promote prevention and develop behaviour change communication;
- to promote partnerships;
- to strengthen monitoring and evaluation.

The objective of the plan developed in 2007 is to contribute to improving the health of infants under the age of 5 with a view to accelerating the achievement of MDGs. The main objective is to reduce by two thirds infant-juvenile mortality from 121 per 1,000 in 2005 to 44 per 1,000 in 2015.

Three strategic focus points have been defined:

- improvement of the availability and accessibility of the integrated intervention package for the health of the mother, newborn and infant;
- increase in the demand and use of services by the population;
- creation of a regulatory institutional environment favourable to the scaling-up of the intervention package.

Five main intervention packages have been selected in this plan:

- prenatal treatment;
- birth and immediate treatment;
- prevention of child diseases including those which can be avoided through immunisation;
- treatment of child diseases.

The monitoring and evaluation of the Child Survival Strategic Plan will be conducted by the NHIS in collaboration with the technical managers of the Divisions and Programmes involved in its implementation.

The objective of the Comprehensive Multi Year Plan of the EPI and of surveillance (2007-2011) is to contribute to reducing infant-juvenile mortality with a view to improving maternal and infant health.

The priorities which are stipulated in this plan include among others:

- eradication and control of diseases which can be avoided by immunisation;
- regular vaccine supply;
- integration with the other health programmes;
- long-term financing of the programme.

The main focus areas selected in the plan are:

- organisation and management of the programme;
- strengthening of capacities;
- waste management;
- vaccine management and logistics;
- delivery of services and integration of activities;
- community involvement and communication;
- surveillance;
- health system strengthening.

Section 3: Situation Analysis / Needs Assessment

To the applicant

GAVI HSS Support: GAVI HSS support cannot address all health system barriers that impact on immunisation and other child and maternal health services. GAVI HSS support should complement and not duplicate or compete with existing (or planned) efforts to strengthen the health system. GAVI HSS support should target "gaps" in current health system development efforts.

- *Please provide information on the most recent assessments of the health sector that have identified constraints and obstacles in the health system. (Table 3.1)*

Note: Assessments can include a recent health sector review (conducted in the last 3 years), a recent report or study on sector constraints, a situation analysis (such as that conducted for the cMYP), or any combination of these. Please attach the reports of these assessments to the application (with executive summaries, if available). Please number them and list them in Appendix 1.

Note: If there have not been any recent in-depth assessments of the health system (in the last 3 years), at the very least, a desk review identifying and analysing the key health systems bottlenecks will need to be undertaken before applying for GAVI HSS support. This assessment should identify the major strengths and weaknesses in the health system, and identify where capacity needs to be strengthened to improve vaccine coverage and to maintain it at the level achieved.

3.1: Recent health system assessments[2]

Title of the assessment	Agencies involved	Areas / themes covered	Dates
MTSEF	- Ministry of Health and Medical Prevention - Ministry of Finance - Development partners	Health funding and expenditures	2007
PRSD	- All Ministries - Development partners	Reduction strategy	2005
Assessment of MDGs	- Ministry of Health and Medical Prevention - Development partners	MDGs, health sector	2005
cMYP	- Ministry of Health and Medical Prevention, WHO, UNICEF, PATH	Epidemiological surveillance and immunisation	2007
Assessment of the PDIS	- Ministry of Health and Medical Prevention - Development partners	Health funding Institutional aspect Fight against diseases Human resources Information system	2003

[2] Within the last 3 years.

Title of the assessment	Agencies involved	Areas / themes covered	Dates
Child Survival Strategic Plan	- Ministry of Health and Medical Prevention, WHO, UNICEF, World Bank, USAID	Newborn, child and maternal health	2007
EDS IV	- Ministry of Health and Medical Prevention - Development partners	Demographic indicators and health	2005
PCIME: Assessment of the quality of care of the under 5 in first level health facilities	- Ministry of Health and Medical Prevention - Development partners	Infant-juvenile health	2007

To the applicant

- *Please provide information on the major health system barriers to improving immunisation coverage that have been identified in recent assessments listed above. (Table 3.2)*
- *Please provide information on those barriers that are being adequately addressed with existing resources (Table 3.3).*
- *Please provide information on those barriers that are not being adequately addressed and that require additional support through GAVI HSS (Table 3.4).*

3.2: Major barriers to improving vaccine coverage identified in recent assessments

1. **Training unsuited to needs**: health personnel from training schools (Regional Training Centre, National Health Development School) do not always meet the needs of the priority health programmes such as the EPI, the PNLP (National Malaria Control Plan), the PNT etc.
   To ensure that priority health programmes are included in the basic training of health personnel, it has been decided to provide the teachers from public and private training schools with a refresher course on the priority health programmes, including the EPI. This should enable the teachers to update their knowledge and provide a better theoretical and practical training of students.
   Furthermore, annual orientation sessions will also be organised for all agents who have recently graduated from the health training schools and who work in regions and districts. Financial resources will be allocated to regions which, with the support of the DRH and health programmes will organise these orientation workshops to enable the agents to be in possession of better tools to manage health programmes.
2. **Insufficient motorised logistics (vehicles and motorbikes) and lack of maintenance of logistic and cold chain equipment:** The implementation of immunisation activities in particular in zones which are not easily accessible require the implementation of advanced or mobile strategies using logistic means (vehicles or motorbikes). Long distances and difficult land conditions in these regions mean that the motorised logistics do not have a very long life cycle due to the lack of adequate means to carry out preventive and curative maintenance of the equipment. Lengthy immobilisation of logistic means following breakdowns greatly hinders the sustainability of advanced and mobile strategies which remain the only solution to provide remote

populations or those in zones which are difficult to access with appropriate curative and preventive health care.

3. **Insufficient supply and management of vaccines:** The low storage volumes of vaccines in certain regional warehouses and in particular in new districts, combined with the poor transport capacities of existing logistic means affect the frequency of supply and consequently the availability of vaccines in certain areas. The lack of lorries at central level and insufficient adequate transport means render the supply of vaccines to certain regions difficult. Non-compliance with norms and guidelines in terms of the management of vaccines and the absence of a monitoring mechanism are at the origin of the stocking of vaccines in certain health facilities and the shortage of vaccines in others.
4. **Insufficient supervision, data management, monitoring and evaluation:** The formative supervision of the personnel of health units is still below the norms in force. And even if the supervision is carried out, the monitoring of the implementation of recommendations is not systemised, which is why the problems noticed are not solved. The completeness, consistency and quality of data remain to be improved due to the multiplicity of report media and the lack of coordination both at central and operational level. Furthermore, the regular analysis of the performance indicators of the EPI at operational level to ensure that the immunisation activities are implemented correctly is still poor. The data collected is not sufficiently used for decision-making and micro planning.
5. **Funding and mobilisation of resources:** With regard to the procurement of vaccines and consumables, the Government has, within the scope of the Vaccine Independence Initiative, entered a budget line for the procurement of vaccines and consumables in the budget of the Ministry of Health. However, the quick mobilisation of these funds remains difficult due to complex administrative procedures. This sometimes leads to vaccine shortages which impact on the performance of the immunisation programme. The insufficient funding of District Operation Plans (POs) hinders an efficient implementation of the planned activities including those pertaining to immunisation. Differences in the development process of the POs with that of the Government's budget means that annual needs in terms of resources are not fully taken into account in the budget of the Ministry in charge of Health.
6. **Insufficient involvement of the community in the implementation of health programmes:** This remark is made in particular for the national immunisation programme where the absence of a structured communication plan, the non-optimal or rational use of the NGOs and CBOs and Associations may explain why parents do not comply correctly with children's vaccine calendars.

3.3: Barriers that are being adequately addressed with existing resources

1- Availability of quality personnel at all levels:

In an endeavour to improve the availability of skilled and motivated health personnel, in particular in difficult zones, a certain number of measures have been taken including among others:

- the implementation of regional training centres in the regions of Kaolack, Saint-Louis and Tambacounda for the past four years; their primary function is to train agents (nursing assistants) from that specific area who are consequently more likely to be want to work there. Training in these schools will be opened to state registered nurse students and midwives to begin with in two centres (Saint-Louis and Kaolack). This will be pursued in 2009 in Tambacounda and will ultimately enable the gap in paramedical personnel to be substantially curbed.

- Each year, the increase in the number of private health training schools means that there is a greater number of qualified nursing personnel, State registered midwives and nursing assistants on the market.
- The Government has implemented an incentive-based remuneration system for health workers working in enclosed and/or difficult regions. This has meant that a large number of health outposts have become operational in these zones. They are run by specialised medical personnel, in particular gynaecologists and paediatricians, thereby strengthening the fight against maternal mortality and infant-juvenile mortality.
- Along the same lines, a personnel motivation system offering standard bonuses has been granted to health workers who are much appreciated by social welfare partners.
- Since 2000 the increase in the number of health workers in the public service (500 workers were recruited in 2006) has helped to solve the personnel shortage problem.

2- Improvement in access to and use of services, in particular in enclosed zones:

The purpose of the redrawing of health districts conducted since 2000 in the largest and most peripheral regions is to bring the health services closer to the population. Indeed, the number of health districts increased from 52 in 2000 to 65 in 2007. The availability of the required personnel and equipment in the majority of new referral health centres and health outposts will strengthen the accessibility, use and quality of preventive and curative health services.

3- Funding of Annual District Work Plans

Within the scope of the funding of immunisation and surveillance activities, the IACC through its technical committee places particular emphasis at operational level on an effective decentralisation of funds based on the micro plans developed by the districts. Within the scope of the implementation of the "Reaching Every District" strategy, funds from GAVI or WHO are directly transferred to the accounts of the medical regions and districts for the implementation of planning activities.

Still with the objective of ensuring a better integration of the PTAs of districts and regions in the national health budget, it was decided to revise the planning cycle of the operational level and to develop annual work plans (PTAs) for the year to come during the first quarter of the current year. This should enable a better assessment of the needs in material, financial and human resources and ensure their integration in the budget forecasts of the Ministry of Health.

4- Improvement in the data management system, and in monitoring and evaluation

The implementation of the NHIS in 2004 is part of the country's desire to benefit from reliable health information and to help planning in the health sector. The health statistics produced contain among others all the performance indicators of the EPI even if the completeness and quality of the data need to be improved.

Within the scope of monitoring and evaluation, periodic meetings are organised by the priority programmes such as the PNLP, the EPI and the PNT with the regions and districts with a view to assessing the main performance indicators of the programmes.

With the adoption of a new health centre and outpost monitoring guide, monitoring is again conducted in some districts. This enables a review of the main programme indicators in terms of availability, accessibility, use and coverage to be carried out every six months. The presentation of monitoring outcomes to the community followed by micro planning with a view to combating the bottlenecks remain the strengths of this activity.

The signing of performance contracts between the MSPM and the districts since 2006 should ensure that there is better compliance with norms and guidelines and that there is also a routine monitoring of district performance. The purpose of these performance contracts which integrate EPI indicators is to improve the quality of health care and the management of health services.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

1- **Training unsuited to needs**: health personnel from training schools (Regional Training Centre, National Health Development School) do not always meet the needs of the priority health programmes such as the EPI, the PNLP (National Malaria Control Plan), the PNT etc. It was thus suggested that a training module included in the courses of study should be developed to ensure that the needs were better taken into account in the training programmes of health personnel (schools, institutes and faculties). Training sessions will also be organised for teachers from public and private training schools on the priority health programmes including the EPI. This should ensure that these agents are better equipped to take into account priority programmes in the courses of study given.

2- **Insufficient personnel motivation in difficult zones:** working conditions do not incite personnel to remain in these zones. Consequently, despite the efforts made by the Government to encourage them to stay, health coverage still needs to be improved. GAVI resources will be able to help the efforts made by the Government to improve the working conditions of these agents through the granting of adequate material and financial means to implement activities.

3- **An insufficient equipment maintenance and replacement system:** the motorised fleet (cars/motorbikes) was implemented between 2002 and 2004 to conduct advanced activities in enclosed or remote zones. There is currently a problem concerning the decay and preventive and curative maintenance of this equipment which is essential to achieve the objectives of the priority programmes such as the EPI. This depreciated equipment or equipment in the process of being depreciated must be replaced to improve the equipping of enclosed zones and new structures which are the most affected. Insufficient adequate financial means and skilled maintenance technicians at operational level necessitate the implementation, thanks to GAVI support, of funds to be used to outsource the maintenance of the cold chain and logistic means. The Directorate of Equipment and Maintenance will be responsible for coordinating and monitoring maintenance service contracts.

4- **Weakness of the operational capacities of districts by placing emphasis on new creations:** the creation of these new districts was motivated by a desire to improve health coverage with a view to providing better access to services. However, these districts are confronted with a need for adequate equipment and skilled and motivated personnel to implement the activities of the health programmes. The funding of this application by GAVI will enable them to procure logistic means (motorbikes, cold chain equipment for the health outposts and warehouses of the districts and regions) with a view to completing the current efforts deployed by the Government to increase the operational capacities of districts.

5- **Insufficient involvement of the community in the implementation of health programmes:** The still somewhat timid or too vertical use of the NGOs, CBOs and Associations in the implementation of health programmes does not favour their approval by the communities. Operational level must use these various organisations and associations to strengthen population awareness and develop community participation in the implementation of health programmes. Within the scope of the implementation of community-based interventions in the fight against malaria, initiatives are in progress to build a solid partnership with the community-based organisations. Consequently, each district works at local level with a CBO network for the implementation of malaria control activities. Technical and financial support (through these GAVI resources) should strengthen the capacities of the associations and organisations to enable them through outsourcing with health services to contribute to the scaling-up of community interventions. Their intervention will be based on an integrated communication plan which will take into account all programmes that aim to improve maternal and infant health as a priority.

6 - Insufficient integration of activities at district level: as the district is the operational level of the health policy, it is essential to strengthen the integration of the activities of the various programmes and in particular those involved in maternal and infant health. Along the same lines, the development, implementation and monitoring of integrated plans would help to ensure a better optimisation and rationalisation of the resources available to achieve objectives. The scaling-up of the PCIME in all districts should contribute to strengthening the integration of activities. This involves training health personnel and regular monitoring of the implementation of the PCIME.

7- Monitoring – evaluation

- Insufficient supervision at operational level: the majority of problems noticed at operational level are linked to insufficient supervision activities. Solving this problem would require the strengthening of personnel capacities, the availability of supervision tools and the provision of logistic and financial means.

- Irregular monitoring: monitoring is a periodic follow-up of activities at operational level using the performance indicators of health programmes. But the non-availability of a computerised media to process and exploit data does not facilitate regular monitoring of micro plans developed to solve the problems at health outposts and centres.

- Completeness of data and coordination of data programme management sub-systems are insufficient: the health information system is confronted with an insufficient integration of hospital and private sector data on the health programmes. The availability of adapted collection media and the training and awareness of hospital and private sector personnel will be maintained and strengthened.
In addition, the poor coordination of the various health programme information sub-systems with the NHIS is the cause of incomplete and inconsistent data. Consequently, backing from the national health information system will provide complete, consistent and reliable data through the implementation of regular coordination bodies with the health programmes.

Section 4: Goals and Objectives of GAVI HSS Support

To the applicant

- *Please describe the goals of GAVI HSS support below (Table 4.1).*
- *Please describe (and number) the objectives of GAVI HSS support (Table 4.2). Please ensure that the chosen objectives are specific, measurable, achievable, realistic and time-bound.*

4.1: Goals of GAVI HSS support

Strengthen the capacities of the health system with a view to improving the performance of the maternal and infant health programmes.

4.2: Objectives of GAVI HSS support

1. Strengthen the skills in maternal and infant health programme management for at least 80% of students at the end of their studies in training schools by the end of 2010;
2. Strengthen the coordination, management, partnership and logistics of the country's 65 health districts by the end of 2010;
3. Ensure the monitoring and evaluation of the 65 health districts on the basis of performance contracts by the end of 2010.

Section 5: GAVI HSS Activities and Implementation Schedule

To the applicant

- *For each objective identified in Table 4.2, please give details of the major activities that will be undertaken in order to achieve the stated objective and the implementation schedule for each of these activities over the duration of GAVI HSS support (Table 5.2 overleaf).*

Note: GAVI recommends that GAVI HSS supports a few prioritised objectives and activities only. It should be possible to implement, monitor and evaluate the activities over the life of the GAVI HSS support.

Note: Please add (or delete) rows so that Table 5.2 contains the correct number of objectives for your GAVI HSS application, and the correct number of activities for each of your core objectives.

Note: Please add (or delete) years so that Table 5.2 reflects duration of your GAVI HSS application

To the applicant

- *Please identify below how you intend to sustain, both technically and financially, the impact achieved with GAVI HSS support (5.1) when GAVI HSS resources are no longer available.*

5.1: Sustainability of GAVI HSS support

In the MTSEF the objective "to improve the motivation and performance of health personnel" takes into account the development of health workers' skills and their availability in zones through the following activities:
- development of a new basic and continuing training plan for health personnel;
- construction of 9 other regional training centres;
- signing contracts with health personnel to work in poor, difficult and enclosed zones;
- implementation of a motivation system for health personnel integrating incentive measures for remote and difficult outposts.

The increase of the operational capacities of districts will be consolidated and sustained through the activities selected in the MTSEF:
- implementation of management teams respecting the norms;
- implementation of an infrastructure and equipment maintenance plan of health facilities;
- implementation of a contracting policy;
- signature of an agreement with the CBOs and Associations for the implementation of health programmes;
- development and implementation of an infrastructure and equipment plan.

Activities relating to the monitoring and evaluation system selected in the application will be strengthened by the activities planned in the MTSEF:
- improvement of monitoring content and expansion to all health units;
- improvement of the quality of supervision at all levels;
- development of information collection mechanisms from private structures, NGOs and development partners;
- carrying out of periodic surveys to assess the efficiency of health programmes.

Funding of these activities will be covered by the budget of the Government, local authorities, population and donors. Resources from HIPC funds through the implementation of the PRSD2, from budget support and from a 15% increase in the health budget will be used to ensure the sustainability of the funding of the priority activities of health system strengthening.

5.2 Alignment of the application with the MTSEF and the Child Survival Strategic Plan

The major activities selected within the scope of the HSS applications mainly aim to develop the implementation capacities of activities at operational level. They concern:

- Strengthening the skills of the teachers of health schools and the health workers that qualify from there: skill strengthening activities will be conducted within the scope
- The improvement of the equipment and logistics upkeep system;
- Outsourcing services with the CBOs and Associations;
- Strengthening data management and the monitoring and evaluation of activities.

These various activities are in line with existing health sector plans, and in particular the MTSEF and the PNSE (National Plan for Child Survival).

- The training activities of teachers and health personnel who qualified from training schools: the MTSEF provides for the development of a training plan and 9 new regional training centres. Training activities will be conducted based on this plan and will be decentralised to the regional training centres.
- Outsourcing maintenance activities will be conducted on the basis of the infrastructure maintenance and health equipment maintenance plan provided for in the MTSEF.
- Outsourcing with the CBOs and Associations provided for in this application will be implemented through the agreement which will be signed between community organisations and districts to implement health programmes within the scope of the MTSEF. Outsourcing will increase the request and use of maternal and infant health services.
- The monitoring and evaluation activities contained in the application based on the performance contracts of districts will place emphasis on data monitoring, supervision, collection and management activities as stipulated in the MTSEF and PNSE.

5.2: Major Activities and Implementation Schedule

Major activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: Strengthen the skills in maternal and infant health programme management for at least 80% of students at the end of their studies in training schools by the end of 2010;												
Activity 1.1: Carry out a situational analysis of the inclusion of the priority needs of maternal and infant health programmes in the courses of study of national health training schools			X									
Activity 1.2: Train in 3 days **31** teachers from national training schools on the EPI and the programmes involved in maternal, newborn and infant health			X									
Activity 1.3: Train in 12 3-day sessions 370 students at the end of their studies at the training schools on the management of maternal and infant health programmes			X									
Objective 2: Strengthen the coordination, management, partnership and logistics of the country's 65 districts by the end of 2010												
Activity 2.1: Organise each year 4 quarterly integrated planning meetings of the activities of programmes involved in maternal, newborn and infant health at central level				X	X	X	X	X	X	X	X	X
Activity 2.2: Support the organisation of a validation workshop of the health map					X							
Activity 2.3: Equip 9 new districts with logistic means (60 motorbikes, 50 refrigerators, 10 freezers)				X								
Activity 2.4: Procure 1 refrigerated lorry to transport pharmaceutical products and vaccines				X								
Activity 2.5: Outsource the maintenance of the motorised and cold chain logistics			X	X	X	X	X	X	X	X	X	X
Activity 2.6: Support the training of 32 health workers and the after-training					X							

Major activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
monitoring on PCIME in the regions												
Activity 2.7: Carry out a situational analysis on the involvement and capacities of the CBOs in the implementation of health programmes				X								
Activity 2.8: Support each district to outsource with 10 CBOs and NGOs for the implementation of health programme activities					X	X	X	X	X	X	X	X
Activity 2.9: Train 10 CBOs in management, planning and monitoring and evaluation of health programmes in each district					X							
Activity 2.10: Support the development of an integrated communication plan of maternal and health programmes and its implementation by 10 NGOs and associations				X	X	X	X	X	X	X	X	X
Activity 2.11: Equip the 3 new medical regions (Kaffrine, Sédhiou, Kédougou) with generating sets				X								
Objective 3: Ensure the monitoring and evaluation of the 65 health districts on the basis of performance contracts by the end of 2010												
Activity 3.1: Organise at central level, 4 monitoring and evaluation meetings for the implementation of integrated health programme activities			X	X	X	X	X	X	X	X	X	X
Activity 3.2: Update the training manual on the Information System for management purposes (SIG)				X								
Activity 3.3: Train/Provide refresher training for the 65 district management teams and the 14 regional management teams on supervision techniques		X										
Activity 3.4: Support the finalisation of the computerisation of monitoring data management					X							
Activity 3.5: Organise a training session on the correct use of management tools for health workers from the public and private sector in each district							X					

Major activities	Year 1 (2008)				Year 2 (2009)				Year 3 (2010)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 3.6: Each year support 2 data validation meetings with the programme data managers at central level			X		X		X		X		X	
Activity 3.7: Each year assess the performance contracts during a meeting of the internal monitoring committee					X				X			
Activity 3.8: Strengthen the supervision logistic means at central level (2 4x4 vehicles)								X				
Activity 3.9: Back 2 supervision outings per year of the Central Level		X		X		X		X		X		X

Section 6: Monitoring, Evaluation and Operational Research

To the applicant

- *All applications must include the three main GAVI HSS impact / outcome indicators:*

i) National DTP3 coverage (%)
ii) Number / % of districts achieving ≥ 80% DTP3 coverage[3]
iii) Under five mortality rate (per 1000)

- *Please list up to three more impact / outcome indicators that can be used to assess the impact of GAVI HSS support on improving immunisation and other child and maternal health services.*

Note: It is strongly suggested that the chosen indicators are linked with application objectives and not necessarily with activities.

- *For all indicators, please give a data source, the baseline value of the indicator and date, and a target level and date. Some indicators may have more than one data source (Table 6.1).*

Note: The chosen indicators should be drawn from those used for monitoring the National Health Sector Plan (or equivalent) and ideally be measured already (i.e. not an extra burden to measure). They do not have to be GAVI HSS specific. Examples of additional impact and outcome indicators are given in the tables below. It is recommended that when activities are implemented primarily at sub-national level that indicators are monitored, to the extent possible, at sub-national level as well.

To the applicant

- *Please list up to 6 output indicators based on the selected activities in section 5. (Table 6.2).*

- *For all indicators, please give a data source, the baseline value of the indicator and date, a target level and date, as well as a numerator and denominator. Some indicators may have more than one data source (Table 6.1).*

Note: Examples of output indicators that could be used, with the related numerator, denominator (if applicable) and data source are shown below. Existing sources of information should be used to collect the information on the selected indicators wherever possible. In some countries there may be a need to carry out health facility surveys, household surveys, or establish demographic surveillance. If extra funds are required for these activities, they should be included.

[3] If number of districts is provided than the total number of districts in the country must also be provided.

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[4]	Source[5]	Date of Baseline	Objective	Date for Objective
1. National coverage by the PENTAVALENT 3 (%)	Administrative data (EPI, NHIS)	89%	Activity reports / Statistics	2006	90%	2010
2. Percentage of districts achieving a coverage ≥80% for the PENTAVALENT 3	Administrative data (EPI, NHIS)	76%	Activity reports / Statistics	2006	80%	2010
3. Under five mortality rate (per 1,000)	Survey	121‰	EDS IV	2005	105‰	2010
4. Percentage of districts having a rate of PNC4 superior to 50%	RH (Reproductive Health)-NHIS reports – Administrative data Monitoring report	N/A	Activity reports / Statistics	Not applicable	50%	2010
5. Percentage of CBOs having conducted integrated activities in accordance with the contracts drawn up with the districts	Administrative data (MR - HD)	100% (malaria activities)	CBO activity reports and monitoring/evaluation meetings	2007	100%	2010
6. Percentage of districts having met the performance contract	Evaluation reports of the performance contracts	N/A	Not applicable	Not applicable	80%	2010

[4] If baseline data is not available indicate whether baseline data collection is planned and when
[5] Important for easy accessing and cross referencing

6.2: Output indicators

Indicator	Numerator	Denominator	Data Source	Baseline Value[4]	Source	Date of Baseline	Objective	Date for objective
1. Number of new districts having received all of the planned equipment	Number of new districts equipped	Total number of new districts	Acceptance report	0	DAGE	Not applicable	10	2010
2. Number of quarterly monitoring meetings/year organised	Number of meetings organised	Total number planned (4)	Minutes of meetings	N/A	Not applicable	Not applicable	4/year	2010
3. Percentage of CBOs trained in management, planning and monitoring and evaluation of health programmes	Number of CBOs trained	Number of CBOs under contract	Training reports	Not available	Not applicable	Not applicable	100%	2010
4. Percentage of training sessions of health workers from the public and private sector conducted on the correct use of management tools	Number of sessions conducted	Number of sessions planned	Training reports	Not available	Not applicable	Not applicable	100%	2010
5. Proportion of districts having outsourced with 10 CBOs on the integrated implementation of maternal and infant health activities	Number of districts having outsourced with the CBOs on priority programmes	Total number of districts involved	HD reports Contracts	Not available	Not applicable	Not applicable	100%	2010

6. Number of NGOs having implemented an integrated communication plan on maternal and infant health	Number of NGOs having implemented an integrated communication plan	10 targeted NGOs	Activities report	Not available	Not applicable	Not applicable	10	2010

To the applicant

- *Please describe how the data will be collected, analysed and used. Existing data collection and analysis methods should be used wherever possible. Please indicate how data will be used at local levels and ways of sharing with other stakeholders in the last column (Table 6.3).*

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcomes			
1. National coverage by the PENTAVALENT 3 (%)	Registration of immunisation activities by the immunisation units Monthly transmission of immunisation reports at district level Compilation of data at district level using a data entry template Transmission of data from the district to regional and central levels	Analysis of data is carried out: - manually at the health outposts - using a data template at district, regional and national levels Vaccine coverage data are compared with the objective and with previous coverage data	Vaccine coverage data is used and shared: - during monitoring meetings with the regions and districts with a view to identifying problems and fixing corrective strategies - through the monthly feedback bulletin at operational level - during the meetings of the technical committee of the IACC with a view to identifying problem districts - during the assessment and development of annual plans
2. Number / % of districts achieving ≥80% of coverage by the PENTAVALENT 3	Registration of immunisation activities by the immunisation units Monthly transmission of immunisation reports at district level Compilation of data at district level using a data entry template Transmission of data from the district to regional and central levels	Analysis of data is carried out: - manually at the health outposts - using a data template at district, regional and national levels Vaccine coverage data are compared with the objective and with previous	Vaccine coverage data is used and shared: - during monitoring meetings with the regions and districts with a view to identifying problems and fixing corrective strategies - through the monthly feedback bulletin at operational level

Indicator	Data collection	Data analysis	Use of data
		coverage data	- during the meetings of the technical committee of the IACC with a view to identifying problem districts - during the assessment and development of annual plans
3. Under five mortality rate (per 1,000)	Population survey MICS-EDSV	The analysis will be carried out according to : - the regions - the social and economic level	The analysis of the data collected will: - improve the delivery and accessibility of maternal and infant health services - enable the progress and trends of infant-juvenile mortality to be assessed
4. Percentage of districts having a rate of PNC4 superior to 50%	The data will be collected from quarterly activity reports which are submitted by the districts to higher levels and will be consolidated with six-monthly monitoring data.	Prenatal consultation coverage data will be analysed in line with the number of districts having achieved the objective set. The analysis will also concern problems pertaining to the accessibility and use of prenatal consultation services.	The information collected will be used to improve the demand, delivery and quality of PNC services, in particular in the less efficient districts. All monitoring data will be shared with all stakeholders during quarterly coordination meetings.
5. Percentage of CBOs having conducted activities in accordance with the contracts drawn up with the districts	The information will be collected from district supervision reports and CBO quarterly activity reports.	The analysis of the information will be conducted on the basis of the outcomes expected in accordance with the contract signed with the district.	The intervention experience of the CBOs will be documented and shared with all players. Also enables an assessment of the additional outcomes of the intervention of the CBOs.

6. Percentage of districts having met the contract performance conditions	Assessment reports of the performance contracts: the district contracts will be assessed annually by the CAS PNDS in collaboration with the NHIS and the health programmes.	The analysis of data will be conducted on the basis of districts having met the contract performance conditions in line with the criteria selected.	The data may be used to strengthen the operational capacities of districts and also to share good practices.
Output			
1. Number of new districts having received all of the equipment planned	The acceptance reports between the districts and the DAGE will provide information on the equipment and logistic means procured and affected to the targeted districts.	The analysis will concern in each district the availability and adequate use of the equipment installed.	This information will allow for solutions to be put forward for an efficient use of equipment and will moreover allow for an analysis of the additional impact of equipment on the districts performance. It will also enable an assessment of technical and logistic means.
2. Number of quarterly monitoring / evaluation meetings organised by the central level	The minutes of the meetings will provide all the information on the date, agenda and participants of these quarterly meetings.	The analysis will be based on the regular holding of the meetings and on the monitoring and implementation of the recommendations made during these meetings.	The information collected will be used to assess and implement application activities at all levels.
3. Percentage of CBOs trained in management, planning and monitoring and evaluation of health programmes	The data will be collected from the main contractor report for this activity together with the reports on the training of the CBOs in all districts.	The analysis will be conducted on the number of CBOs trained per district and on the results of the training.	This information will enable a list to be drawn up in each district on the number of CBOs trained and operational.

4. Percentage of workers from the health schools and newly recruited having participated in orientation sessions.	The data will be collected from training reports: each region will submit a training report giving the number of workers who have been recently affected and who have participated in the orientation sessions, and will detail the topics covered.	The analysis will be conducted on the number of agents trained and the results of the training.	This information will allow for recommendations to be made to ensure a better post-training monitoring and a formative supervision of these newly-recruited agents at their workstation.
5. Proportion of districts having outsourced with 10 CBOs on the integrated implementation of maternal and infant health activities	The data will be collected from the contracts signed with the CBOs and submitted by each district.	The analysis of the data will concern the number of contracts signed with the CBOs, on their experience, focus points and performance.	This information will be used to document the added value and share good outsourcing practices.
6. Number of NGOs having implemented an integrated communication plan on maternal and infant health	The data will be collected from the activity reports of the NGOs which have signed contracts and which are regularly sent to the CAS-PNDS and to the SNEIPS (National Department of Health Education and Information).	The analysis of data will be conducted on the basis of NGOs having met the performance contract conditions in line with the criteria selected.	Also allows for an assessment of outcomes of the intervention of the NGOs (demand and use of the services)

To the applicant

- *Please indicate if the M&E system needs to be strengthened to measure the listed indicators and if so describe which indicators specifically need strengthening. (Table 6.4).*
- *Please indicate if the GAVI HSS application includes elements of operational research that address some of the health systems barriers to better inform the decision making processes and to have a better understanding of health outcomes. (Table 6.5).*

6.4: Strengthening M&E system

6.5: Operational Research

It was decided not to conduct operational research within the scope of this application.
Nevertheless, we suggest a situational analysis to:
- ensure the inclusion of the priority needs of maternal and infant health programmes in the courses of study of the national health schools
- assess the involvement and capacities of the CBOs in the implementation of health programmes

Section 7: Implementation arrangements

To the applicant

- *Please describe how the GAVI HSS support will be managed (Table 7.1). Please also indicate the roles and responsibilities of all key partners in GAVI HSS implementation (Table 7.2).*

Note: GAVI encourages aligning GAVI HSS with existing country mechanisms. Applicants are strongly discouraged from establishing project management units (PMUs) for GAVI HSS. Support for PMUs will only be considered under exceptional circumstances, based on a strong rationale.

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of the person / group responsible for managing the implementation of GAVI HSS support / M&E etc.	The technical committee of the health system strengthening system, coordinated by Dr Papa Coumba Faye, Director of Medical Prevention, will be responsible for the management of the implementation of GAVI support.
Role of the HSCC (or its equivalent) in the implementation of GAVI support and M&E	After approval of the application, the national steering committee for health system strengthening (CNPRSS) will be responsible for: 1. studying and approving annual implementation plans and monitoring and evaluation 2. monitoring the implementation of planned activities 3. approving monitoring and evaluation reports 4. approving technical and financial audit reports

Coordination mechanism of GAVI HSS support with the other activities and programmes of the system	The National Steering Committee for Health System Strengthening (CNPRSS) was implemented to monitor health system strengthening activities. The committee was created by ministerial order. It is chaired by the Secretary General of the Ministry of Health and Medical Prevention and coordinated by the manager of the Support and Monitoring Unit of the PNDS. It also has a select technical committee chaired by the Director of Medical Prevention. This committee will be responsible for organising meetings to coordinate and develop integrated implementation and monitoring plans (Please refer to the ministerial memorandum no. 03303/MSPM/CAS/PNDS of the 8 May 2007. The committee will ensure that there is no duplication of resources and activities of the various programmes. Moreover, it will monitor the implementation of the integrated plans. The technical committee will be responsible for assisting the CNPRSS in the monitoring and assessment of the implementation of activities.

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

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the implementation of GAVI HSS support
Programme Focal Points	WHO	yes	Technical support: (1) Development of plans, (2) Monitoring and evaluation of implementation, (3) Development of periodic reports.
Programme Focal Points	UNICEF	yes	Technical support: (1) Development of plans, (2) Monitoring and evaluation of implementation, (3) Development of periodic reports.
Technical advisors	PATH	no	Technical support: (1) Development of plans, (2) Monitoring and evaluation of implementation, (3) Development of periodic reports.
Health Programmes Focal Point	CONGAD	no	Implementation of community awareness and mobilisation activities: Assessment of community-based activities

Partners which include WHO, Unicef, PAT Hand GONGAD participate in the various coordinating and monitoring meetings. They assist the CAS-PNDS in the validation of the plans submitted by the districts.

WHO, Unicef and PATH will participate in the supervision missions at central level to ensure the proper implementation of the activities contained in the application. These partners will also provide support in the assessment of performance contracts and in the development of annual progress reports pertaining to the application.

The CONGAD assists in the identification of the NGOs and CBOs which have skills in community mobilisation with a view to outsourcing communication activities.

To the applicant

- *Please give the financial management arrangements for GAVI HSS support. GAVI encourages funds to be managed 'on-budget'. Please describe how this will be achieved (Table 7.3).*
- *Please describe any procurement mechanisms that will be used for GAVI HSS (Table 7.4).*

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country	A special account in local currency will be opened in a commercial by the DAGE of the Ministry of Health and Medical Prevention in the name of the Health System Strengthening Programme/GAVI (PRSS/G) and will be given to the GAVI Secretariat. New funds will be transferred to the special account on the basis of annual progress reports.
Mechanism for channelling GAVI HSS funds from central level to the periphery	After outsourcing with the districts and community-based organisations, they will be requested to open a sub-account to be used exclusively for GAVI funds. DAGE will be given the account number. Funds will be transferred to the sub-accounts from the special account in line with quarterly requests submitted by the districts and with a validated report.
Mechanism (and responsibility) for budget use and approval	Financial management of GAVI support is carried out by the DAGE. Statements of needs are emitted by the departments, districts and community organisations involved in the implementation of project activities after validation by the CAS/PNDS and the DPM. Budgets will be disbursed by the DAGE upon presentation of the request approved by the departments of the CAS/PNDS and the DPM.
Mechanism for disbursement of GAVI HSS funds	These requests will be drawn up by the departments, districts and community organisations in line with a quarterly plan of action for the first call for funds and thereafter upon presentation of supporting documents and upon presentation of the activity report for the previous prior in the case of renewal.
Use and justification of funds	Disbursements of funds to fund project activities and justification will be conducted in line with the management procedures manual of the PNDS II (Please refer to the procedure manual in the appendix.)

Auditing procedures	An annual financial audit will be organised at the initiative of the Support Unit for the implementation of Projects and Programmes (CAP) within the MEF. The CAP will be responsible for the development of the TOR and for outsourcing with an external audit firm in collaboration with the DAGE and the CAS/PNDS at the Ministry of Health and Medical Prevention. The unit will comply with any external audit that GAVI chooses to conduct.

7.4: Procurement and supply mechanisms

Goods and services will be procured in line with Government contract awarding procedures further to decree 2007- 545 of the 25 April 2007 which stipulates the contract procurement code by the departments of the DAGE, DEM, MEF and in collaboration with the departments involved.

Procurement planned within the scope of this applications concerns motorbikes, refrigerators and freezers, 4x4 vehicles and a refrigerated lorry.

1. Good procurement procedures:

- Collection of needs
- Development of technical specifications
- Development of tender offer file
- Submission of the tender offer files for approval by the DCMP
- Publication of tender offer files
- Filing and opening of calls to tender
- Technical assessment of tender offers
- Submission of the results of the technical assessment for approval by the DCMP
- Signature of the contract and negotiations
- Approval of the procurement contract by the DCMP and administrative departments
- Notification of the approved tender offer

2. Service procurement procedures

- Development of the TOR
- Expression of interest to draw up a shortlist
- Opening of tender offers
- Submission of shortlist and TOR to the DCMP
- Transmission of proposals request
- Opening of technical tender offers
- Technical assessment
- Awarding of contract on technical aspects
- Filing of financial tender offers
- Awarding of contract on financial aspects
- Signature of the contract and negotiations
- DCMP approval
- Notification of the approved tender offer

7.5 Outsourcing mechanism towards community organisations:

On the basis of the Operational Outsourcing Guide drawn up by the Ministry of Health and Prevention, terms of reference will be developed for each district in order to select the 10 most efficient CBOs of their zones. Each CBO will have to justify a legal status and have at least two years' experience of activities in the zone.

In accordance with the performance contracts, the districts will be required to draw up contracts with the CBOs selected based on their monitoring and evaluation plan of action. These plans of action should reflect the activities planned in the annual district work plans.

Each CBO will be required to budget its plan of action which will be validated by the district and by the CAS-PNDS. The CBOs will receive the funds allocated periodically from the districts upon presentation of the previous quarterly activities report together with supporting documents and a plan of action for the quarter to come.

The monitoring of the implementation of activities is carried out by the monitoring committee created at district level and at central level by the SNEIPS.

To the applicant

- *Please describe arrangements for reporting on the progress in implementing and using GAVI HSS funds, including the responsible entity for preparing the APR. (Table 7.5)*

Note: The GAVI Annual Progress Report, due annually on 15 May, should demonstrate: proof of appropriate accountability for use of GAVI HSS funds, financial audit and proper procurement (in line with national regulations or via UNICEF); efficient and effective disbursement (from national to sub-national levels; in the context of a SWAp mechanism, if applicable); and evidence on progress on whether expected annual output targets and longer term outcome targets are being achieved.

7.5: Reporting arrangements

Periodic activity reports will be developed in accordance with the intervention levels:

Central Level: The Directorate for Medical Prevention will be responsible for:

(1) drawing up the reports of the various coordinating meetings (IACC, HSS Steering Committee, Central directorates and departments;
(2) drawing up a quarterly summary of the various activity reports of the departments and districts involved;
(3) producing an annual technical and financial report pertaining to the application;
(4) initiating the production of an annual audit report.

Peripheral Level: The districts and community-based organisations will be required to:

(1) produce monthly activity reports;
(2) produce six-monthly and annual activity reports;
(3) produce a monthly summary of CBO reports;
(4) facilitate the implementation of an annual audit.

To the applicant

- *Some countries will require technical assistance to implement GAVI HSS support. Please identify what technical assistance will be required during the life of GAVI HSS support, as well as the anticipated source of technical assistance if known (Table 7.6).*

7.7: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Situational diagnosis of the involvement of the CBOs in the implementation of health programmes	45 days	4th quarter 2008	Local
2. Situational analysis of the inclusion of the priority needs of health programmes in the courses of study of national health training schools	30 days	4th quarter 2008	Local

To the applicant

- *Some countries will require technical assistance to implement GAVI HSS support. Please identify what technical assistance will be required during the life of GAVI HSS support, as well as the anticipated source of technical assistance if known (Table 7.6).*

Section 8: Costs and Funding for GAVI HSS support

To the applicant

- *Please calculate the costs of all activities for the duration of the GAVI HSS support. Please add or delete rows / columns to give the right number of objectives, activities and years. (Table 8.1)*

Note: Please ensure that all support costs for management, M&E, and technical assistance are included. Please convert all costs to US $ (at the current exchange rate), and ensure that GAVI deflators are used for future costs (see guidelines on the GAVI website: www.gavialliance.org).

Note: The overall total request for GAVI HSS funds in table 8.1 should not exceed the overall total of GAVI HSS funds allocated in table 8.2. Funds may be requested in annual trenches according to estimated annual activity costs. These may vary annually from the allocation figures in table 8.2.

8.1: Cost of implementing GAVI HSS support activities

Area for support	***Cost per year in US $ (1,000)***				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL COSTS**
	2008	2008	2009	2010	
Activity costs					
Objective 1: Strengthen the skills in maternal and infant health programme management for at least 80% of students at the end of their studies in training schools by the end of 2010		**81,450**	**63,900**	**63,900**	**209,250**
Activity 1.1: Carry out a situational analysis of the inclusion of the priority needs of maternal and infant health programmes in the courses of study of national health training schools		PM	PM	PM	**PM**

Activity 1.2: Train in 3 days **31** teachers from national training schools on the EPI and the programmes involved in maternal, newborn and infant health		17,550	0	0	**17,550**
Activity 1.3: Train in 12 3-day sessions 370 students at the end of their studies at the training schools on the management of maternal and infant health programmes		63,900	63,900	63,900	**191,700**

Area for support	***Cost per year in US $ (1,000)***				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL COSTS**
	2008	2008	2009	2010	
Activity costs					
Objective 2: Strengthen the coordination, management, partnership and logistics of the country's 65 districts by the end of 2010		**733,013**	**1,133,825**	**922,350**	**2,789,188**
Activity 2.1: Organise each year 4 quarterly integrated planning meetings of the activities of programmes involved in maternal, newborn and infant health at central level		1,763	7,050	7,050	**15,863**
Activity 2.2: Support the organisation of a validation workshop of the health map		0	37,800	37,800	**75,600**
Activity 2.3: Equip 9 new districts with logistic means (60 motorbikes, 50 refrigerators, 10 freezers)		387,500	0	0	**387,500**

Activity 2.4: Procure 1 refrigerated lorry to transport pharmaceutical products and vaccines		125,000	0	0	**125,000**
Activity 2.5: Outsource the maintenance of the motorised and cold chain logistics		81,250	162,500	162,500	**406,250**
Activity 2.6: Support the training of 32 health workers and the after-training monitoring on PCIME in the regions		0	33,600	0	**33,600**
Activity 2.7: Carry out a situational analysis on the involvement of the CBOs in the implementation of health programmes		PM	PM	PM	**PM**
Activity 2.8: Support each district to outsource with 10 CBOs and NGOs for the implementation of health programme activities		0	650,000	650,000	**1,300,000**
Activity 2.9: Train 10 CBOs in management, planning and monitoring and evaluation of health programmes in each district		0	177,875	0	**177,875**
Activity 2.10: Support the development of an integrated communication plan of maternal and health programmes and its implementation by 10 NGOs and associations		62,500	65,000	65,000	**192,500**
Activity 2.11: Equip the new medical regions (Kaffrine, Sédhiou, Kédougou) with a generating set		75,000	0	0	**75,000**
Objective 3: Ensure the monitoring and evaluation of the 65 health districts on the basis of performance contracts by the end of 2010		**207,781**	**213,063**	**93,863**	**514,706**

Activity 3.1: Organise at central level, 4 monitoring and evaluation meetings for the implementation of integrated health programme activities		881	1,763	1,763	**4,406**
Activity 3.2: Update the training manual on the Information System for management purposes (SIG) Activity 3.2: Update the training manual on the Information System for management purposes (SIG)		42,750	0	0	**42,750**
Activity 3.3: Train/Provide refresher training for the 65 district management teams and the 14 regional management teams on supervision techniques		56,700	0	0	**56,700**
Activity 3.4: Back the finalisation of the computerisation of monitoring data management		0	37,500	0	**37,500**
Activity 3.5: Organise a training session on the correct use of management tools for health workers from the public and private sector in each district		0	25,000	0	**25,000**
Activity 3.6: Each year back 2 data validation meetings with the programme data managers at central level		34,200	68,400	68,400	**171,000**
Activity 3.7: Each year assess the performance contracts during a meeting of the internal monitoring committee		4,950	4,950	4,950	**14,850**
Activity 3.8: Strengthen the supervision logistic means at central level (2 vehicles 4x4)		125,000	0	0	**125,000**
Activity 3.9: Back 2 supervision outings per year of the Central Level		12 000	12 000	13 500	**37 500**

Area for support	*Cost per year in US $ (1,000)*				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL COSTS**
	2008	2008	2009	2010	
Activity costs					
Support costs		12,500	12,500	12,500	**37,500**
Management costs		0	7,500	7,500	**15,000**
Support the project audit costs		29,500	10,000	10,000	**49,500**
Technical support		**1,132,944**	**1,347,338**	**1,104,863**	**3,585,145**
TOTAL COSTS					

To the applicant

- *Please calculate the amount of funds available per year from GAVI for the proposed GAVI HSS activities, based on the annual number of births and GNI per capita[1] as follows (Table 8.2):*

- *If GNI < $365 per capita, country is eligible to receive up to $5 per capita*
- *If GNI > $365 per capita, country is eligible to receive up to $2.5 per capita*

8.2: Calculation of GAVI HSS country allocation to Senegal

GAVI HSS allocation	**Allocation per year (US $)**				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2008	2008	2009	2010	
Birth cohort	466,310	466,310	477,968	489,917	
Allocation per newborn	2.5 US $	2.5 US $	2.5 US $	2.5 US $	
Annual allocation		**1,165,775 US $**	**1,194,920 US $**	**1,224,793 US $**	**3,585,488**

Source and date of GNI and birth cohort information:

GNI: Ministry of Finance (GDP 740 US $ per capita in 2006)

Birth cohort and population: NHIS ,2006

Birth rate (39 per thousand) and rate of infant mortality (61 per thousand): EDS IV , 2005

Natural growth rate (2.5%) ANSD, 2006

***To the applicant**:*

Note: Table 8.3 is not a compulsory table.

- *Please endeavour to identify the total amount of all expected health system strengthening related spending in the country during the life of the GAVI HSS application (Table 8.3).*

Note: Please specify the contributions from the Government, GAVI and the main funding partners or agencies. If there are more than four main contributors, please insert more rows. Please indicate the names of the partners in the table, and group together all remaining expected contributions. Please indicate the source of the data (Public Expenditure Review, MTEF, donor reports etc).

8.3: Sources of all expected funding for health systems strengthening activities

Funding sources	**Allocation per year (US $)**				
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	**TOTAL FUNDS**
	2008	2008	2009	2010	
GAVI		1,132,944	1,347,338	1,104,863	3,585,145
Government		286,427,781	286,427,781	286,427,781	859,283,343
Total World Fund		827,809	18,976,799	17,754,059	37,558,667
Local Authorities		9,485,714	9,485,714	9,485,714	28,457,142
Populations (Health Committees)		54,648,352	54,648,352	54,648,352	163,945,056
TOTAL FUNDING		**352,522,600**	**370,885,984**	**369,420,769**	**109,2829,353**

NB: Funding sources of the World Fund per programme

World Fund (HIV/AIDS)		18,490,345	16,928,555	35,418,900
World Fund (Malaria)	752,201	284,257	760,716	1,797,174
World Fund (TB)	75,608	202,197	64,788	342,593

Source of information on funding sources:

GAVI: Senegal Application for GAVI HSS 2008-2010.....

Government MTSEF 2008 - 2010 .....

Donors: MTSEF 2008 - 2010.....

Local Authorities: MTSEF 2008 - 2010.....

Populations: MTSEF 2008 - 2010.....

Total World Funds: Round 7 Senegal Application to the World Fund – Tuberculosis, Malaria and HIV/AIDS components

Section 9: Endorsement of the Application

To the applicant:

- *Representatives of the Ministry of Health and Ministry of Finance, and the Chair of the Health Sector Coordinating Committee (HSCC), or equivalent, should sign the GAVI HSS application.*
- *All HSCC members should sign the minutes of the meeting where the GAVI HSS application was endorsed. This should be submitted with the application (numbered and listed in Appendix 1).*
- *Please give the name and contact details of the person for GAVI to contact if there are queries.*

Note: The signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.

9.1: Government endorsement

The Government of Senegal undertakes to provide immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:	***Ministry of Finance:***
Name: **Dr Safiatou THIAM**	Name: **Mr Abdoulaye DIOP**
Title / Post: **Minister of Health and Prevention**	Title / Post: **Minister of State, Minister of the Economy and Finance**
Signature:	Signature:
Date:	Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting held on the 14 December 2007. The signed minutes are attached as Appendix 1.

Chair of HSCC (or equivalent):

Name: **Moussa Mbaye**	Post / Organisation: **Secretary General of the Ministry of Health and Prevention**
Signature:	Date:

9.3: Person to contact in case of enquiries:

Name: Dr Mandiaye LOUME **Title:** CAS/PNDS Coordinator

Address: Ministry of Health and Prevention
Boite Postale 45383 Dakar - Fann
Code Postal 12522 Dakar, Sénégal

Telephone number Office: (+221) 33 869 42 72 Mobile: (+221) 77 642 44 63

FAX number (+221) 33 869 42 04

E-mail: mandiaye.loume@hotmail.com

APPENDIX 1 Documents Submitted in Support of the GAVI HSS Application

To the applicant:

- *Please number and list in the table below all the documents submitted with this application.*

Note: All supporting documentation should be available in English or French, as electronic copies wherever possible. Only documents specifically referred to in the application should be submitted.

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
PNDS	yes	2004-2008	1
National Plan for Child Survival	yes	2007-2015	2
cMYP and Excel Tool on funding	yes	2007-2011	3
MTSEF[6]	yes	2008-2010	4
PRSD II[8]	yes	2006-2010	5
Recent health sector assessment documents (Assessment of the MDGs, PCIME Assessment, PDIS Assessment)	yes	1 to 4 years	6
Minutes of the HSCC meeting, signed by the HSCC Chair	yes	Meeting held on the 14 December 2007	7

[6] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

DETAILED BUDGET FIRST YEAR

Main activities	Year 1				Total YEAR 1	REMARKS
	2008					
	Q1	Q2	Q3	Q4		
Objective 1: Develop the skills of health personnel on the management of programmes involved in maternal and child health						
Activity 1.1: Carry out a situational analysis of the inclusion of health programme strategies in the courses of study of national health training schools					$ -	Exhaustive survey among health schools (ENDSS and regional schools) to assess how they incorporate the minimum skills required for the management of maternal and child health programmes (Expanded Programme on Immunisation, Reproductive Health, Division of Food, Nutrition and Child Survival) in the training courses. This activity requires **technical assistance** to be implemented and is estimated at 12,500 Dollars (5,000,000 CFA Francs). A 1/3 of the amount will be given to the consultant at the beginning of their work and the remaining 2/3 when their report is submitted. (Please refer to the heading technical assistance below)
Activity 1.2: Train in 3 days **31** teachers from national training schools on the EPI and the programmes involved in maternal, newborn and infant health				$ 17,550	$ 17,550	Further to the results of the survey, this activity involves the training of 31 teachers for 3 days (3 in each of the 8 regional centres and 7 from the ENDSS) for a cost of 60,000 CFA Francs/person/day. This amount covers the cost of accommodation and transport. The same applies to the 4 trainers who will conduct the training for 3 days for a cost of 120,000 CFA Francs/trainer/day.
Activity 1.3: Train in 12 3-day sessions 370 students at the end of their studies at the training schools on the management of maternal and infant health programmes				$ 63,900	$ 63,900	The budget of the activity is as follows: [(**5 trainers** x 25,000 CFA Francs/day x 3 training days) x 12 sessions] + [(**30 students** x 17,500 CFA Francs/day x 3 training days) x 12 sessions] + [(**5,143 CFA Francs of material per person** x 35 people per session) x 12 sessions]
Total Objective 1				$ 81,450	$ 81,450	

Objective 2: Increase the operational capacities of districts						
Activity 2.1: Organise each year 4 quarterly integrated planning meetings of the activities of programmes involved in maternal, newborn and infant health at central level				$1,763	**$1,763**	In order to avoid the overlapping of activities at operational level, 4 1-day meetings are planned with partners. The following budget represents the cost of a meeting: - for 30 participants at a cost of 20,000 CFA Francs/day (coffee break and lunch, per diem and transport) - and for 15 partners at a cost of 7,000 CFA Francs representing catering costs **in other words ((30*20,000)+(15*7,000)) = 600,000 CFA Francs/meeting**
Activity 2.2: Support the organisation of a validation workshop of the health map					**$0**	Activity programmed in 2009.
Activity 2.3: Equip 9 new districts with logistic means (60 motorbikes, 50 refrigerators, 10 freezers)				$387,500	**$387,500**	This involves strengthening the logistics means of the new districts in order to improve their performance. The following procurement is planned for these 9 districts: - 60 motorbikes at 2,000,000 CFA Francs the motorbike - 50 refrigerators at 500,000 CFA Francs the refrigerator - 10 freezers at 1,000,000 CFA Francs the freezer
Activity 2.4: Procure 1 refrigerated lorry to transport pharmaceutical products and vaccines				$125,000	$125,000	The lorry is estimated at 55,000,000 CFA Francs.
Activity 2.5: Outsource the maintenance of the motorised and cold chain logistics			$40,625	$40,625	$81,250	The infrequency of maintenance activities was raised as a weak point. To remedy this situation, this plan suggests a support of 1,000,000 CFA Francs/district for the country's 65 districts.
Activity 2.6: Support the training of 32 health workers and the after-training monitoring on PCIME in the regions					$0	Activity programmed in 2009.

Activity 2.7: Carry out a situational analysis on the involvement of the CBOs in the implementation of health programmes					$0	In order to constitute a network of community-based organisations involved in the implementation of programmes at operational level, we suggest carrying out a preliminary study to enable us to measure their effective involvement in the said programmes. The survey has been initially programmed for the 4th quarter of 2008. It requires **technical assistance** for its implementation and is estimated at 17,000 Dollars (6,800,000 CFA Francs). Payment terms are 50% at the beginning of the work and the remaining 50% when the report is submitted. (Please refer to the heading on technical assistance below).
Activity 2.8: Support each district to outsource with 10 CBOs and NGOs for the implementation of health programme activities					$0	Activity programmed in 2009.
Activity 2.9: Train 10 CBOs in management, planning and monitoring and evaluation of health programmes in each district					$0	Activity programmed in 2009.
Activity 2.10: Support the development of an integrated communication plan of maternal and health programmes and its implementation by 10 NGOs and associations				$62,500	$62,500	Communication activities still represent a weakness in the implementation of health programmes. In order to ensure their sustainability and to allow for a better monitoring and evaluation of these activities, it is planned to outsource with 10 NGOs and Associations at national level for an amount of **2,500,000 CFA Francs/NGO or association**
Activity 2.11: Equip the new medical regions (Kaffrine, Sédhiou, Kédougou) with a generating set				$75,000	$75,000	The new regions suffer from a lack of material resources. **The cost of a generating set is estimated at 10,000,000 CFA Francs.**
Total Objective 2	$0	$0	$40,625	$692,388	$733,013	

Objective 3: Develop the monitoring – evaluation system of health programmes						
Activity 3.1: Organise at central level, 4 monitoring and evaluation meetings for the implementation of integrated health programme activities			$441	$441	$881	For the first year of implementation, 2 monitoring / evaluation meetings are planned. The following budget represents the cost for one meeting: - with 8 participants at 19,400 CFA Francs/day (coffee break and lunch, per diem and transport) - with 3 partners for a cost of 7,000 CFA Francs representing catering fees **in other words ((8*19,400)+(3*7,000)) = 176,200 CFA Francs/meeting**
Activity 3.2: Update the training manual on the Information System for management purposes (SIG)				$42,750	$42,750	In order to update the information system for management purposes, a 5-day workshop for 57 people is planned bringing together all the health pyramid, at a cost of 60, 000 CFA Francs/person (catering, per diem and transport) in other words **5*57*60,000 = 17,100,000 CFA Francs**.
Activity 3.3: Train/Provide refresher training for the 65 district management teams and the 14 regional management teams on supervision techniques					$0	Activity reprogrammed programmed in 2009
Activity 3.4: Back the finalisation of the computerisation of monitoring data management					$0	Activity programmed in 2009
Activity 3.5: Organise a training session on the correct use of management tools for health workers from the public and private sector in each district					$0	Activity programmed in 2009
Activity 3.6: Each year back 2 data validation meetings with the programme data managers at central level			$34,200		$34,200	For the first year of implementation, 1 data validation meeting is planned with the data programme managers at central level. This validation will be conducted in the form of a 4-day workshop for 57 people bringing together all managers including the central level, at a cost of 60,000 CFA Francs/person (catering, per diem and transport) in other words 4***57*60,000 = 13,680,000 CFA Francs**

Activity 3.7: Each year assess the performance contracts during a meeting of the internal monitoring committee					$4,950	Activity programmed in 2009
Activity 3.8: Strengthen the supervision logistic means at central level (2 4x4 vehicles)				125,000	$125, 000	Activity programmed in 2009
Activity 3.9: Back 2 supervision outings per year of the Central Level					$6,000	Activity programmed in 2009
Total Objective 3	$0	$0	$34,641	$168,191	$213,781	
Support costs						
Management costs				$12,500	$12,500	
Support costs for M&E					$0	
Technical assistance			$12,500	$17,000	$29,500	
Total support costs	$0	$0	$12,500	$29,500	$42,000	
Grand Total	$0	$0	$87,766	$971,528	**$1,070,244**	