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The Global Fund
To Fight AIDS, Tuberculosis and Malaria

GAVI ALLIANCE

Health Systems Funding Platform (HSFP)

Health Systems Strengthening (HSS) Support

COMMON PROPOSAL FORM

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

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

This form is structured in three parts:

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

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

Part A - Summary of Support Requested and Applicant Information

Applicant:	**Ministry of Public Health and the Fight Against AIDS**			
Country:	**Burundi**			
WHO region:	**Africa**			
Proposal title:	**Health System Strengthening for improved immunization performance**			
Proposed start date:	**January/2013**			
Duration of support requested:	**Three years**			
Funding request:	**Amount requested from GAVI:**	**12 900 000**	**Amount requested from Global Fund:**	
Currency:	◉ USD		○ EUR	

Contact details	
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Executive Summary
→ *Please provide an executive summary of the proposal.*

Drawing inspiration from the Comprehensive Multi-year Plan for the EPI 2011 – 2015 and the National Health Development Plan 2011 – 2015, the project has set itself the aim of reducing the disease and mortality linked to vaccine-preventable diseases by ensuring population access to quality immunization services with a view to improved utilization. The Objectives, Performance Areas and Activities of the project are as follows:

Objective 1: To strengthen capabilities for delivering and using quality immunization services

Area 1.1: Community activities and services - performance, use and quality: to **multiply** and distribute booklets for community health agents (CHAs).

Area 1.2: Strategic and operational planning: to organize support missions by the EPI and its partners for the executive teams of 19 health districts with GAVI HSS support in analysis and micro-planning within the framework of the "Reach Every District" (RED) strategy every year.

Area 1.3: Financial resources: to participate in financing the operating costs of measles immunization monitoring campaigns, local polio immunization days, and Mother-Child Health Weeks, and contribute to financing the organizational expenses of African Vaccination Week (AVW).

Area 1.4: Awareness-raising, communication and social mobilization: to produce communication and social mobilization tools to improve immunization demand and use, purchase equipment to produce the communication tools, purchase and replenish consumables on a yearly basis, organize awareness-raising social mobilization campaigns for the "RED" strategy on a six-monthly basis, pay the transport expenses of CHAs in the course of social mobilization campaigns in the framework of the "RED" strategy, and contribute to organizing the re-launching of the new rotavirus vaccine.

Area 1.5: Surveys, research and evaluation: to organize six-monthly evaluation meetings on vaccine management and quality in 45 health districts (HDs) and contractually commit local associations working in the spheres of responsibility of GAVI-supported health centers as regards the conduct of community satisfaction surveys on immunization services.

Area 1.6: Purchase and logistics chain management: to purchase photovoltaic refrigerators for sectarian and private facilities.

Area 1.7: Health personnel: to train and/or recycle health district (HD) managers, HD head physicians and multi-purpose supervisors on vaccine management and the "RED" approach, train the national

rapid-action team (ENIR), the HD units and the provincial health authorities (BPS) as well as heads of health centers (HC) regarding the new monitoring tools for diseases of high epidemic potential.

Objective 2: To contractually commit peripheral health facilities and CBOs with a view to improving the performance of district vaccination units with low immunization coverage rates

- **Area 2.1: Financial resources:**to contribute to contractually involving 223 CBOs in the spheres of responsibility of health centers and of six line agencies in the six GAVI-supported provinces.
- **Area 2.2: Healthcare financing:**to contribute to purchasing the performance activities of 223 HCs through services related to the “fully vaccinated children” and “tetanus-vaccinated pregnant women” indicators.

Objective 3: To ensure access to vaccines and the rational management of the supply chain, logistics and medical products and equipment safety.

- **Area 3.1: Material resources - infrastructure and products of prime necessity:** to contribute to the purchase and distribution of long-term ITNs for the 19 BDS supported and to purchase working tool kits for the CHAs.

- **Area 3.2: Purchase and logistics chain management:**to purchase 25 10 KVA generators for the HDs, ensure cold chain maintenance in the 6 GAVI-supported provinces, purchase a 40 KVA generator for the EPI and 13380 liters of gas for the Health Center refrigerators in the area of intervention, pay a yearly fire insurance policy for EPI depots, purchase 19 double-cabin vans for supply distribution, supervision and additional immunization activities of HCs on the part of the District Health Offices of the 6 provinces, ensure the maintenance of the 19 double-cabin vans on a quarterly basis, purchase 4 double-cabin vans for the EPI to supervise immunization activities and monitor EPI target diseases, and to pay for the insurance of the 19 double-cabin vehicles.
- **Area 3.3: Infrastructures:** To replenish the stocks and rehabilitate the offices of the EPI also housing the HSS/GAVI management unit and purchase syringe destroyers for the 223 HCs of the 19 GAVI-supported BDS.

Objective 4: To strengthen the system of health information and M&E on community interventions

Area 4.1: Monitoring and documentation of community and government interventions: to harmonize data-gathering tools on the community level, prepare Health Information System tools for gathering community and civil register data, contribute to the conduct of a KAP survey on EPI performances and organize a national workshop on the validation of community data-gathering tools.

Area 4.2: Regular data gathering, analysis and processing: to multiply and distribute 735 data-gathering tools a year revised by health centers**.**

Area 4.3: Health personnel: To train the staff charged with the HIS on the revised data-gathering tools.

Area 4.4: Surveys, research and evaluation: to conduct a survey on immunization coverage

Area 4.5: Management and organization of establishments: to update the biomedical waste management plan

Objective 5: To ensure programme management.

Area 5.1: Management and governance: To ensure the operation and strengthening of HSS/GAVI management unit technical capabilities.

The key purposes and activities described above for health system strengthening will improve the performance of the immunization programme units by placing particular emphasis on equality in the universal access to immunization services. This project will make it possible to reach marginal or underprivileged populations such as: the Batwa ethnic group, persons not contacted and the wives and children of seasonal or migrant workers. Moreover, the quality and integration of the units on the operational level, the effective involvement of communities, the efficient use of resources and the reliability of health information will be strengthened.

The budget requested from the GAVI Alliance amounts to US$ 12 900 000.

The implementation of the KARADIRIDIMBA project will be ensured by health facilities (hospitals and public, private and sectarian health centers) as well as by the community organizations and agents from the project intervention area. Performance monitoring in project implementation will be ensured by means of the coordination mechanisms in place, while respecting the circuit defined by the NHIS.

Part B - Applicant Eligibility

If this application includes a request to the Global Fund, please fill out the eligibility and other requirements section available here.

If this application includes a request to GAVI, please click here to verify the applicant's eligibility for GAVI support.

Table 1: HSS Financing

HSS External Funding

→ Please fill in the below table outlining all HSS support from external funders. Please add columns as needed fo
funders.

	GAVI	World Bank		Embassy of Belgium	UNFPA	
Time-frame	2007-2012	2009-2014	2012-2017	2010-2013	2010-2014	2011-
Funding Amount	8 251 000 USD	39 800 000 USD	15 000 000 USD	25 000 000 Euro	16 500 000 USD	1 034 EUI
Areas of Support	All six pillars of HSS	Services, Health financing, Leadership and	Services, Health information systems, Health financing, Health	All six pillars	All six pillars except health financing	All six pil except infrastruc

		governance	personnel			
Geo-graphic Location	In 4 targeterd provinces (Bururi, Gitega, Kayanza et Mwaro)	All country	All country	All country	All country	Bururi, Bubanza Bujumbu Makamb Rutana, Karusi, C

Part C - Proposal Details

1. Process of developing the proposal

1.1 Summary of the proposal development process

→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.

ONE PAGE MAXIMUM

The procedure used in preparing the present proposal was coordinated jointly by the Partnership Framework for Health and Development (CPSD), which included the Inter-agency Coordination Committee (ICC) and the Burundi CCM up to the announcement of the Global Fund withdrawal for Round 11. The call for proposals launched was widely distributed by the CCM among the public, private and association stakeholders on 26 August 2011 (Annex: 6) by means of an official communiqué made through the different media channels of the written and spoken press. Prior to this, authorization to prepare and submit the present proposal was granted by the CCM at its general assembly on 26 July 2011 (Annex 7) following the analysis of a concept note prepared for the purpose and approved by the CPSD at its ordinary meeting of 23 September 2011 (Annex 8). The Minister of Public Health and the Fight against Aids, Chairman of the CCM and the CPSD, on 26 August 2011, set up an extended technical committee to draw up multi-sector Round 11 proposals and take charge of the entire process of preparing the proposal, with one among its 4 committees being charged with drawing up Round 11 HSS proposals. This in turn was composed of 3 subcommittees, among them a coordination committee, a technical team to draw up the proposal, and a revision committee (Annex 9). The composition of these committees took account of the involvement of civil society, which has participated in all the stages of the process to prepare the proposal. It must also be noted that members of civil society participated in the body that coordinated and strategically monitored the process of preparing the proposal, namely, the CPSD. A calendar reflecting the different proposal preparation stages was drawn up by the CCM at the general assembly (Annex 10).

After the Global Fund withdrawal for Round 11, monitoring the process of HSS proposal preparation was coordinated by the CPSD.

The CPSD was kept informed regularly during the meetings of 23 September and 29 October 2011 of the progress of preparations regarding the present proposal (Annexes 11 and 12). This latter approved the proposal and authorized its submission to GAVI on 26 March 2012 (Annex 13).

The preparation process was amply supported by the Technical and Financial Partners (TFP) through the technical assistance of their professionals and a financial consultant from the World Bank.

Information gathering, its compilation and the analysis of health system strengthening needs were based on data from different sources, most important among which are: the situational analysis report in the framework of the National Health Development Plan 2011-2015, the NHDP for 2011-2015, the Comprehensive Multi-year Plan for the EPI (cMYP 2011-2015) , METF 2011-2013, the NHDP evaluation report 2006-2010, human resources mapping in health for 2010, the evaluation reports on service quality in the Health Facilities (FOSA) of Burundi, the Joint Report Forms (JRF 2005-2010), the HSS-GAVI annual status reports (ASR 2005-2010), the report on the analysis of needs and capabilities of civil society organizations intervening in health affairs, EDS 2010, the strategic plan of the National Health Information System, the statistical yearbook of 2010, and the manual on the procedures of performance-based financing.

The NHDP budget for 2011-2015 includes all potential national and foreign funding sources, including the support of the GAVI ALLIANCE. The implementation period of the present proposal (2013-2015) is amply covered by the current NHDP. The financial cycle of the subsidy requested also ties in fully with the national financial calendar, which extends from January to December of each year (Annex 14: Budget Law, establishing national payment schedules and budgets). The annual budgets granted by GAVI within the framework of this proposal will be included in the yearly national budgets.

The quality assurance of the proposal document has benefited from the critical analyses and recommendations raised by peers in the course of the revision workshop organized by the WHO, the Global Fund and GAVI in HARARE from 13 to 16 December 2011, by the revision committee, the Inter-country Support Team units of the WHO in Central Africa, and the CPSD. The technical committee subsequently took account of critiques, integrated the recommendations from all sides, and verified with the help of a checklist that they satisfied the eligibility criteria set by the GAVI ALLIANCE. Afterwards, the CPSD expressed its support and authorized the transmission of the proposal to GAVI.

1.2 Summary of the decision-making process

→ Please summarise how key decisions were reached for the proposal development.

ONE PAGE MAXIMUM

The decisions regarding the formulation of the present HSS proposal to GAVI were successively made by the CCM and the CPSD up to the date of Global Fund withdrawal for Round 11. Subsequent developments were taken care of solely by the CPSD. It should be underscored that decisions in the CPSD are taken by consensus in accordance with its terms of reference (Annex 15: CPSD Terms of Reference). The process of preparing the present proposal made reference to the Strategic Framework for the Fight against Poverty, 2nd generation (CSLP 2), the strategic planning tool to which all sectors refer. As specific for the health sector, proposal preparation referred to NHDP 2011 – 2015. The objectives and activities contained in the framework of this proposal represent the operational forms of NHDP 2011 – 2015. It was during the CPSD meeting held on 23 September 2011 that the criteria for defining HSS objectives were established, which are as follows: the presumed urgency of the pertinent interventions, their feasibility, the status of their previous implementation, the absence or insufficiency of resources allocated to them, and their expected impact on the target diseases of the immunization programme. (Annex 11).

The chosen objectives were drawn from the EPI Multi-year Plan (cMYP 2011-2015) approved by the CPSD on 11 May 2011 (Annex 16).

The cMYP itself (2011-2015) made reference to the Global Immunization Vision and Strategy (GIVS 2006-2015) and aims to contribute towards the improvement of results with regards to immunization. The objectives adopted were presented to and approved by the extended committee before the preparation of the logframe. Moreover, NHDP 2011-2015 took account of the challenges expressed in the current cMYP, since this preceded its preparation.

The Ministry of Public Health (MSPLS) unit managing the GAVI/HSS funds will be charged with coordinating activity implementation. The Health Facilities (FOSA), the District Health Offices (BDS),

the Provincial Health Offices (BPS) and community agents will be charged with actual activity implementation. These latter already have tested experience in the implementation of health programmes, but the reinforcement of their capabilities will be sought within the framework of this support.
Strategic monitoring of the activities will be guaranteed by the CPSD, which avails of specialized groups with heads in charge of M&E who analyze programme monitoring reports. The annual status reports of GAVI HSS support are analyzed by the specialized group on funding and approved by the CPSD, which decides.

There is a close relationship between the decision-making process taking place within the context of preparing this proposal and the decision-making processes applied in the health sector. In effect, decision-making throughout this process falls upon the CPSD, which is the decision-making body of the health sector. Moreover, the CPSD, the decision-making body of the health sector that has existed since 2007 and has continually coordinated and strategically monitored all health sector strengthening interventions, has benefited from the technical insights of the select committee drafting HSS Round 11, which necessitated its set-up. The composition of this committee is multi-sectoral, with the involvement of civil society, represented by 4 members coming from community, sectarian, private and non-government organizations (NGOs).

2. National Health System Context

2.1 a) National Health Sector

→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.

2.1 b) National Health Strategy or Plan

→ Please highlight the goals and objectives of the National Health Strategy or Plan.

2.1 c) Health Systems Strengthening Policies and Strategies

→ Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems, health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.)

FOUR PAGES MAXIMUM

2.1 a) National health sector

In Burundi, the health situation continues to be a source of preoccupation marked by the predominance of many transmissible and non-transmissible diseases. Life expectancy at birth is estimated at 49, with 51.8 years for women and 46 for men[1]. Gross mortality rate is estimated at 16.5 per 1000, with a ratio of maternal mortality at 500 for every 100 000 live births[2]according to EDS 2010–and this ratio differs from that reflected in NHDP 2011 - 2015, which situates the figure at 866, as per General Population and Housing Census 2008–an infant mortality rate of 59 for every 1000, and an under-five mortality of 96 for every 1000 live births[3].

The main causes of disease in children under 5 are respiratory infections, the most frequent among them being pneumonia (22.4% in 2009), diarrheal diseases (9%), and chronic malnutrition, which particularly affects children under 5 (58%). ***As regards mortality, pneumonia occupies the first place with 29%, followed by diarrhea (21%) and malaria (10%)[4].***

The fight against **vaccine-preventable diseases** remains a health system priority. The EDSB 2010 survey shows that the results of routine immunization exceed 85% for the greater part of the antigens. Fully vaccinated children came up to 83% according to the same survey. This favorable national coverage rate hides disparities between the health districts. In effect, 4 health districts (HDs) in 45 (8.8%)[5] do not reach 80 % of the coverage for pentavalent 3 and 10 HDs (22%) do not come up to 80 % of the coverage for measles immunization.

The Burundi healthcare system is organized in pyramidal form and is divided into 3 levels: central, intermediate and peripheral.
The central level groups together the Minister's office, the permanent secretariat, a General Health Inspection office, three General Directions, 3 personalized institutions, 13 departments, 9 health programmes and the related services. The intermediate level is composed of 17 provincial health offices

1 General Population and Housing Census, 2008

2 Demographic and Health Survey of Burundi 2010, preliminary data (EDSB 2010)

3 EDSB, 2010

4 UNICEF, Country Profile, 2010

5 Plan Pluri Annuel Complet du PEV 2011

(BPS). The BPS are charged with the coordination of all the provincial health activities, give support to health districts, and ensure good cooperation between sectors. The peripheral level is composed of 45 health districts covering 63 hospitals (41 of them public, 8 sectarian and 14 private for-profit establishments) and 735 health centers[6] (423 of them public, 105 sectarian and 207 private for-profit establishments) distributed throughout the 129 communes of the country. Each district covers 2 to 3 communes composed of between 100 000 and 150 000 inhabitants. The private sector occupies a choice position in the Burundi health sector. In effect, it is calculated that 35% of hospitals, 42% of health centers and 84% of paramedical training schools belong to the private sectarian sector. The communities are involved in the health system through community-based organizations (CBOs), health committees and community liaisons that ensure contact between health center and community (awareness-raising, treatment, support and drop-out recovery).

The **healthcare network** operates on three levels: the basic level, the first referral level and the national referral. A package of activities is defined at each level, covering curative, preventive, promotional and rehabilitation healthcare.

Geographic accessibility is satisfactory since the population in general (80%)[7] is able to access a health center less than 5 km away, although there are geographical disparities working above all in favor of urban centers.

As regards human resources, the total workforce of 15,941 health agents is broken down into 5,957 nurses, 418 doctors and medical trainees, 16 midwives, 827 qualified paramedic staff, and 8,739 other workers. As to the doctors, overall ratio for the entire country is 1 doctor for every 19,231 inhabitants, whereas the WHO standard recommends a ratio of 1 doctor for every 10,000 inhabitants, very far from this reality. The ratio of nurses to inhabitants is satisfactory, with one nurse for every 1349 inhabitants (the WHO standard being one nurse for every 3 000). It is to be pointed out that more than 50.5% of the doctors and 21%[8] of the nurses are practicing in Bujumbura.

According to the National Health Accounts of 2007, the health sector funding sources are: 17% public (ministries, including funds from the HIPCI and public entities), 43%[9] private (40% of which are from households and the rest from associations, sectarian and non-sectarian NGOs, businesses) and 40% from foreign aid.

The Civil Service Mutual Fund (MFP) covers State employees and their beneficiaries; i.e., 10%[10] of the population of Burundi. The Health Card (CAM) was initiated by the Government of Burundi in 1984 to benefit certain low-income populations. Insurance and private mutual company initiatives are beginning to sprout up, even though they only represent 0.1% of health expenses[11] in 2007.

2.1 b) National health strategy or plan

NHDP 2011-2015 preparations were the subject of a participative process that involved all the actors in the health sector, its technical and financial partners, and civil society. The various documents produced were validated regularly by an NHDP Steering Committee and the Consultation Framework of Partners for Health and Health Development (CPSD). These process coordination, planning and monitoring authorities are composed of health managers and managers from the related government sectors, the TFPs and NGOs/private sector associations. The CPSD serves as a framework for permanent dialogue among all the actors involved in the health system, including civil society. It holds an ordinary meeting once a month. Every year, it organizes a joint review of national strategy implementation. Within the

[6] EPISTAT: Statistical Yearbook, 2001
[7] Poverty Expenditure Tracking Survey (PETS), 2008
[8] Poverty Expenditure Tracking Survey (PETS), 2008
[9] National Health Accounts, Burundi 2007, August 2009.
[10] National Health Accounts, Burundi 2007, August 2009.
[11] National Health Accounts, Burundi 2007, August 2009.

implementation framework of the 2005-2015 National Health Policy, Burundi has just finished preparing NHDP 2011-2015.
The NHDP for 2011-2015 aims to improve the state of health of the population, not only because it is a human right, but also to re-launch the economy and decrease poverty, while maintaining human assets in good health[12].
Health improvement in the population will entail the attainment of three (3) general goals with respect to MDGs 4, 5 and 6: (i) To contribute to the reduction of mortality in children under 5; (ii) To contribute to the reduction of maternal and neonatal mortality; (iii) To contribute to the reduction of disease and mortality due to transmissible and non-transmissible diseases. The sector's objective is *to ensure the population's access to quality healthcare and health services with a view to improved utilization*.

Immunization is one of the NHDP priorities taken into account in the strategic thrust of "strengthening quality healthcare and health services (in preventive, curative, promotional and rehabilitation healthcare) on all levels of the health system" with a particular emphasis on strengthening prevention activities through immunization, including the introduction of new vaccines.
With a view to linking the Medium Term Expenditure Framework for 2011 – 2013 to the NHDP, correspondences have been established between the items structuring the NHDP (objectives, strategic thrusts, results expected and measures) and the key elements of the MTEF architecture. Thus, the pillars of the NHDP are based on the MTEF concept of "strategic thrust", and the basis for the strategic axes of the NHDP are found in the MTEF "programmes"; that of the "expected results" may be assimilated to the "sub-programme", and that of the measures to the "project".

2.1 c) Health system strengthening policies or strategies

Burundi avails of a human resources development plan in health for the 2010-2014 period, aiming in general to improve the management of human resources and increase their availability and qualifications. The specific objectives aim, among other things, to improve coverage in the more isolated areas, with a view to achieving better health results in general, and with regard to immunization in particular. Among the objectives of the strategy of performance-based funding is staff motivation, with a view to ensuring employee stability in the sector, based on the improvement of the indicators related to immunization.

In the pharmaceutical sector, the government is in the process of preparing the following documents on policy and legislation: National Pharmaceutical Policy and the National Pharmaceutical Law. The certification and registration of pharmaceutical products and vaccines are reflected in their texts of implementation. Within the framework of improving medical stock management in general and vaccine stock management in particular, the PBF strategy contains an indicator relating to stock shortage monitoring in district health facilities and pharmacies.

With a view to improving financial accessibility to healthcare, including immunization, in favor of the more vulnerable groups, the government has adopted a policy of free healthcare to children under five, Caesarian births, childbirth, and pregnancy-related pathologies.
Burundi has a national contracting policy in the health sector and, since 2006, has opted for a funding strategy based on performance. This strategy is aimed at attaining five objectives, among them, that of strengthening the management, autonomy and organization of health facilities. PBF makes it possible to involve community-based organizations (CBOs) in immunization activities on the one hand, and to take account of the population's point of view in the management and resolution of health problems on the

[12] Ministry of Public Health, National Health Policy 2005 – 2015, September 2004

other.
In 2010, the government linked PBF to the free character of services, with a view to improving management in the reimbursement of invoices in such cases. This strategy was intensified starting 01 April 2010.
A Strategic Plan for the National Health Information System (NHIS) 2011 – 2013 exists, with four strategic thrusts: I) strengthening of coordination, planning and leadership; II) strengthening of human and financial resources, equipment and infrastructures; III) improvement of health data sources, management and quality; and IV) improvement of health information production, distribution and use. The implementation of this strategy contributes to the performance of EPI activities, particularly in terms of improvement in quality, timeliness and completeness of epidemiological and statistical data in general, including EPI data.

The National Policy as regards health gives priority to equitable geographic coverage in terms of health infrastructure and equipment. Indeed, more than 80% of the population has access to health services less than five kilometers away on foot, a situation favoring the use of immunization services.

On the national level, there is a Partner Coordination Group (PCG), a high-level political and strategic authority grouping together all the national sectors and development partners, with a technical body in the National Aid Coordination Committee (CNCA). On the health sector level, the Government has set up a Consultation Framework of Partners for Health and Health Development (CPSD), which serves as a platform for permanent dialogue among all the actors of the health system, including civil society. The CPSD is a statutory framework for all decisions concerning national health programme funding, including the EPI. Community health in Burundi is a new approach in health promotion. To institute this approach, the Ministry of Public Health and the Fight against AIDS recently validated a document of strategic orientations in community health in the course of a national workshop organized at the end of September 2011. These strategic orientations generally aim to contribute to the improvement of the population's health by strengthening the involvement of communities in health treatment. The specific objectives pursued are, above all: (i) To improve the planning, implementation, coordination and M&E system for community health action on all the levels of the health pyramid; (ii) To increase the community commitment through the participation of community agents, civil society associations and representatives of vulnerable and marginal groups, among them the Batwa and partners, with a view to improving community health on the level of households and groups; (iii) To increase the access and use of promotional, preventive, curative and rehabilitation healthcare services by improving their availability and accessibility for the population in general and for vulnerable and marginal groups in particular. Achievement of these objectives will make it possible to improve the access to and use of immunization services.

Decentralizing the health system through the institution of 45 health districts is one of the great reforms initiated by the Government. These represent the operational units of the healthcare system. The health district consolidates the community level together with health centers (HCs) and the district hospital, which is the hospital of first referral.

2.2 Key Health Systems Constraints

→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).

TWO PAGES MAXIMUM

Leadership and governance:

On the national, provincial and district levels, insufficiencies are noted in the control mechanisms relating to the management of public property. Unequal distribution, coupled with the inefficient resource management, likewise constitutes a principal constraint in this area. On the institutional and legal plane, the shortcomings and misinterpretations of certain legislative texts and regulations, such as the implementation documents of the health districts, and the texts and laws governing the health information system, are also difficulties observed in the area of governance. Limited technical capabilities likewise affect the implementation of different reforms on all levels, including decentralization (low capabilities in executive district teams and community agents). The community level has still not been sufficiently integrated into the health pyramid. As a result of the absence of texts governing the organization and role of community agents, there is perceptible confusion between the Health Committees (COSAs) and the Community Health Agents (CHAs) as to respective attributions, a weakness in the coordination of community liaison and community actors. In addition, there is record of many CHAs managed by different programmes, a competition between different community actors and a lack of vocal capacity on the part of civil society organizations.

Human resources production and management

In general, it is observed that, in the more underprivileged regions, there is often no more than a single doctor and HCs are still being run by health assistants. The low motivation of staff linked to the working environment and the high personnel turnover are some of the other main constraints in this area. The new district physicians and heads of health centers require training sessions in capacity upgrading. There is a perceptible qualitative insufficiency on the part of paramedical personnel, partly explained by the lack or insufficiency of training on the level of public and private teaching establishments. All in all, there is no national plan for the continuing education of health sector staff. In a word, the unequal geographic distribution of personnel remains a challenge to be met.

Funding system for health

That part of the State budget allocated to the health sector remains insufficient (11.9% in 2011) in relation to the standards recommended by the Abuja Accord (15%), according to the sector statistics produced by the Ministry of Finance. The stability of funding for the PBF strategy remains a preoccupation and the funding gap is estimated at 10 to 30 million dollars for 2012[13].

Health information and M&E system:

The Management of the NHIS is suffering from a lack of material, financial and human resources to ensure the success of its mission of gathering, processing, analyzing and distributing health information on all the levels of the health pyramid.

A low capacity for data analysis and interpretation has been noted on the level of the provinces and health districts. Data management in hospitals faces difficulties related to the adaptation of internal supports and data-gathering tools insufficiently filled up (births, deaths, epidemic cases and health coverage). There is likewise no storage system for data, and there is insufficient feedback information between the different levels. The weekly report on diseases of epidemic potential, among them measles, meningococcus, etc., shows a certain delay as a result of the lack of efficient means of communication. The same applies to the report on the incidence and mortality of diseases under surveillance, transmitted monthly. The six-monthly and yearly data evaluation workshops conducted with the health provinces, districts, programmes and projects are not held with regularity. On the

[13] Report of the PBF Joint Evaluation Mission in Burundi, October 2010

community level, there is no system for gathering and processing routine data. Also noted is a lack of harmonized data gathering tools that would enable evaluation of performances on the community level.

Purchase, stocks and logistics management system

The major constraints in this area are: the strong dependence on foreign funding for the purchase of medicines and vaccines; low storage and management capacities on all levels; the lack or deterioration of the means of supply (logistics); untimely power failures, posing a maintenance problem for the cold chain and vaccine preservation; and the insufficiency of surveillance, as well as the notification of Adverse Events Following Immunization (AEFI), posing a challenge to the safety of injections.

Service delivery

On the national level, improving mother and infant health to contribute to the reduction of maternal and infant mortality remains a challenge. On the provincial and district levels, the Health District Hospitals (HDHs) offer both the minimum package of activities and the supplementary package, which is sometimes incomplete. On the community level, the capabilities to supply services and the use of quality vaccination services still remain insufficient. Indeed, the minimum package of activities has still not been defined, harmonized or coordinated due to the lack of a national implementation strategy for community-based activities. Likewise perceptible is the low technical capability of the District Executive Teams for micro-planning within the framework of the "Reach Every District" strategy. As regards IEC/BCC, lack of coordination in the structure of communication on all levels and insufficient communication to orient measures for behavioral change has also been observed.

In sum, analysis of the current health system reveals constraints linked to the different components of the health system that restrict immunization programme performance. Notable are the inequality in universal access, the low community participation, the insufficiency of resources and their inefficient use, and restricted health information of limited reliability.

Key populations such as marginal or underprivileged groups are: the Batwa ethnic group, persons not contacted, wives and children of seasonal or migrant workers (fishermen, gold panners, forest occupants with constraints specific to their groups, which are: stigmatization, poverty, ignorance, and physical accessibility, just to cite a few).

2.3 Current HSS Efforts

→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.

THREE PAGES MAXIMUM

A leadership and governance system

In what regards the matter of public finances, reforms have been made, management procedures and systems have been improved by updating the fundamental texts (the framework law on public finance, the Code on Public Contracts, the Customs Code) and the public finance information management system. The strengthening of the section charged with internal control in the MSPLS represents opportunities for ensuring transparency and appropriate management. Financial audits on health facilities have been initiated with regard to the financing agreement signed between the government and the World Bank in 2009. Civil society is intensely committed to the fight against the misappropriation of funds. This notably takes the form of the Organization Combatting Corruption and Economic Misappropriation (OLUCOME), the Government Action Observatory (OAG), Word and Action to Awaken Awareness and the Evolution of Mentalities (PARCEM)…

With regard to the unequal allocation of resources, Burundi, with the cooperation of its partners in 2008, prepared the national accounts for health and the medium term expenditure frameworks for 2009-2011 and 2011-2013, instruments making it possible to identify and correct the unequal distribution of resources. Moreover, the health standards prepared in 2008 are undergoing updates in order to produce coverage expansion plans and health cards on all the levels of the health system.

In terms of sector regulation and standardization, a step has been taken with the adoption of texts that regulate the health sector, in particular: the manual of procedures for PBF implementation, the manual of procedures on community health, the health district operations guide, etc. Community participation initiatives in health problem management have been developed, setting up elected health committees (with the support of different partners) and training agencies for community actors (with the support of the World Bank). In the coordination framework of PBF implementation, an expanded technical panel for TFPs and civil society has been set up.

Within the framework of strengthening technical and managerial capabilities, the various levels of the MSPLS and the community actors are benefiting from the technical support and joint M&E missions on the different reforms and vaccination programme activities conducted by different technical and financial partners.

Human resources

The current health system strengthening measures in this area are: availability of a development policy and plan on human resources in health, with a decentralized thrust in the management of human resources; a mapping of the human resources in health, a database of human resources managed on the level of all health districts, and an observatory of human resources. Key partners who supported the above activities are Swiss Cooperation and the WHO. The yield in general practitioners and nurses is satisfactory at present. Since the PBF approach was applied nationwide, coverage in these two personnel categories has perceptibly improved, even in the isolated areas. The key partners supporting PBF are the World Bank, the CTB, the EU, GAVI Alliance, HealthNetTPO, the Global Fund, USAID, etc. GAVI-HSS applies PBF in five health districts. In addition, the Government has taken other motivating measures, among others, subsidizing personnel healthcare: the specific provisions of the general statute of civil service, which grants specific indemnity premiums to health personnel. The efforts undertaken in terms of health facility equipment and the construction of homes for healthcare personnel working in isolated health facilities likewise contribute to motivating personnel. In a word, the MSPLS, with the support of the TFPs, organizes training in strengthening the technical capabilities of health personnel in general and EPI personnel in particular. The staff screened for the EPI are the Health Center heads as well as the vaccine managers. This activity is sustained with funds from ISS and other partners such as USAID.

Funding system for health

The macroeconomic framework for 2011-2014 shows that the health sector represents a government priority. That part of State expenses excluding debt allocated to the health sector rises from 11.7% in 2010 to 14.9% in 2014[14]. In view of the increased access of certain categories of vulnerable population to healthcare, in May 2006, the Government of Burundi decided to implement the policy of free healthcare for children under 5, including healthcare services linked to pregnancy and childbirth in public and related health facilities.

So as to ensure the feasibility of PBF, the Government has undertaken to allocate 1.4% of the national State budget to the free healthcare policy each year, representing 50% of the cost of PBF. The MSPLS

[14] Note to budget framework 2012-2014

is in the process of undertaking efforts to rationalize the policy of free healthcare, mobilize additional financial resources and reduce the unit prices of certain indicators.

The government is in the process of restructuring and generalizing the use of the Health Card, instituted in 1984 to reduce the burden of health expenses on households, thus improving financial access to healthcare.

With the support of its financial partners (CTB, WB EC), the MSPLS is in the process of undertaking measures to strengthen capabilities as regards financial management on all levels. This will involve, among other things, training District Management Teams as regards finance and accounting management and training the heads of health centers in the use of finance management tools.

Health information system

Statistics Law no. 1/17 of 25 September relating to the organization of the country's statistical system has been instituted. This was followed by the appointment of the members of the national statistical information council and the members of the technical committee on statistical information. A strategic plan for the National Health Information System (2011-2015) has been validated by all stakeholders so as to improve NHIS performance for M&E on the implementation of NHDP 2011-2015 and the MDGs directly related to health. This involves the preparation of a metadata dictionary, the acquisition of the materials appropriate on all levels, and the strengthening of personnel capabilities as regards use of the IT tool and the analysis and interpretation of data. The EPISTAT office has just been replaced by an NHIS Department, the mission of which is to coordinate the gathering, processing, analysis and distribution of health information to all levels.

The MSPLS has just updated the template for routine data-gathering in a participative way, in public, private and conventional health facilities, attempting to integrate the highest number of specific programme indicators, among them the EPI.

A national communication plan has been prepared and validated to ensure the coherence of communications, coordination and the proper orientation of the different health agents in general as well as with particular reference to immunization. The GAVI HSS funds provide support in the acquisition and maintenance of the IT tool and in the strengthening of the technical capabilities of the users in their area of intervention. The CTB began its intervention in September 2011 to ensure corrective and preventive maintenance of the IT tool on all levels for a period of one year. A document of projected support for the NHIS by the CTB was validated on 07 October 2011. This project aims to support the strengthening of capabilities for the NHIS, among them the production of data-gathering tools, including tools for use on the community level.

Purchase, stocks and logistics management system

The decentralization of the cold chain on the Health District level is supported by UNICEF (33 freezers, 24 refrigerators), GAVI HSS (17 generators in provincial administrative centers, 120 SIBIR refrigerators, fuel in all HCs), and USAID (19 refrigerators and 6 freezers). As regards supply, GAVI HSS endowed 12 districts with supply vehicles and their fuel and maintenance up to the end of 2011. As regards stock management and injection safety, GAVI ISS supports the training of health center heads and stock managers. The WHO contributes logistics support for all activities related to the surveillance of vaccine-preventable diseases.

Delivery of services

The health standards on the operational level define the minimum package of activities on the HC level and the supplementary package of activities on the health district hospital level was validated in 2008. These packages cover preventive care and services, including immunization services. A process of updating health standards and preparing coverage expansion plans in terms of infrastructures, human resources and medical equipment, is in course to improve the geographical access of the entire population to health services. With the implementation of PBF, efforts to improve the quality of healthcare have been observed. The public-private sector partnership is a reality in the health sector. Indeed, 35% of sectarian and private health facilities have signed agreements with the MSPLS. In the private facilities, agents combine preventive care and health promotion in the services. These facilities sign contracts with the MSPLS in the framework of PBF implementation. CSOs intervene in immunization activities.

The community level communication strategy is sustained by the national reproductive health programme and other partners.

As regards the fight against transmissible diseases, the surveillance report on diseases of epidemic potential is transmitted weekly from the operational level to the central level (to NHIS management). Afterwards, the data are processed, analyzed and shared with the health emergency preparation and response unit and the WHO.

As regards the community package, a document on strategic community health orientations has just been prepared. Currently, health center management involves the community in the healthcare system by setting up health and HC management committees. The community is likewise represented by community liaison agents who ensure communication between health center and community. Healthcare Groups (HGs) represent a community strategy based on volunteer work for disseminating essential health messages to households. The volunteers are selected by the community upon recommendation of the village head and organized into groups of ten to twelve members. They elect a person in charge from among themselves acknowledged as a community model who is called the "Leading Mother or *Mère Lumière*". The Leading Mothers in turn form healthcare groups of ten or more "Leading Mothers". Culturally adapted methods are used to strengthen their capabilities as agents of behavioral change in the community. This Healthcare Group may be expanded and used for vaccination activities.

As regards IEC/BCC, activities on the central level are conducted through the IEC unit, which prepares and distributes magazines in Kirundi twice a week through the service contract signed between the Ministry of Public Health and the Fight against AIDS and the National Radio and Television of Burundi, some of which magazines deal with the immunization programme.

On the intermediate and peripheral level, the Provincial Coordinators of Health Promotion coordinate communication and health promotion activities in general and immunization activities in particular. Within the framework of PBF implementation, local community associations are regularly involved in the community verification of health facility services and in the evaluation of perceived quality and beneficiary satisfaction as regards health services (supported by the World Bank, the European Commission, Cordaid, HealthNetTPO and CTB).

In relation to the use of GAVI Alliance support for Civil Society Organizations (CSOs) type A, all the CSOs intervening in the field of immunization and health system strengthening have been identified, followed by the recruitment of four of their representatives. As regards type B, funds have enabled the conduct of the following activities: (i) improvement of immunization coverage in the healthcare facilities of four CSOs financed by GAVI, (ii) support to community health associations and Red Cross volunteers for mobilization and awareness-raising in favor of immunization, (iii) training of CHAs, religious and community leaders as well as health caregivers in the area of immunization, (iv) acquisition of awareness-raising tools favoring Immunization along with working tools (umbrellas, boots, etc.).

Thanks to all these efforts described above, immunization coverage is highly satisfactory, exceeding 90% for the principal antigens according to the annual EPI report for 2010. The MPS national survey for 2009 showed that immunization coverage rates were higher than 80% for the principal antigens[15] (Polio3 :87.3%, DTC3 or Penta 3: 95.4%, and AMV: 94,3%). The EDS 2010 survey likewise shows that the results of routine immunization exceed 85% for the greater part of the antigens. Fully vaccinated children came up to 83% according to the same survey.

[15] EDSB, 2010

3. Health Systems Strengthening Objectives

3.1 HSS objectives addressed in this proposal

→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.

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The relationship between the objectives of this proposal and those of the National Health Development Plan 2011-2015 and the Comprehensive Multi-year Plan for the EPI 2011 – 2015 is described below:

i) The first objective: "to strengthen the capabilities to supply and use quality immunization services" will contribute to the implementation of NHDP 2011 – 2015 through its first strategic thrust, ***"strengthening quality healthcare services (preventive, curative, health promotion and rehabilitation) on all health system levels"***[16]. This objective will, moreover, contribute to meeting the challenges set forth in the cMYP 2011 – 2015 and in the NHDP 2011 – 2015 situational analyses as described in Section 2 of the present proposal.

ii) The second objective: "To contractually commit peripheral health facilities and community-based organizations towards improving the performance of immunization services in districts with low immunization coverage rates" is based on thrust no. 7 of NHDP PNDS 2011 – 2015 ***"Strengthening and propagation of PBF associated to the free character of healthcare"*** and the strategy of ***"Pursuing contractual commitment in performance"*** contained in cMYP 2011 – 2015.

iii) The third objective: "To ensure access to vaccines and a rational management of the supply chain, logistics and the safety of medical equipment and products" ties in with the implementation of the NHDP 2011 – 2015 thrust ***"Availability and population access to quality medicine and other health products"*** and the strategies: ***"Expansion of implementation for the "RED" approach in all districts, Introduction of the pneumococcus vaccine, Introduction of the second measles dose and the rotavirus vaccine into routine EPI nationwide, Improvement of vaccine management, Improvement of storage capacity, Improvement of the cold chain maintenance system, Strengthening of capabilities on injection safety"*** of cMYP 2011 – 2015.

iv) The fourth objective: "To strengthen the system of health information and M&E on community interventions" fits in with the sixth NHDP 2011-2015 thrust, ***"Strengthening systems of health information, planning and evaluation"*** and the strategies: ***"Improvement of AEFI monitoring, Reinforcement of staff data management capabilities, Improvement of the communication system, Strengthening of the passive and active AFP monitoring system"*** contained in cMYP 2011-2015.

v) The fifth objective: "Ensuring programme management" is rooted in the fifth thrust ***"Strengthening governance and leadership in the health sector"*** of NHDP 2011-2015 and will contribute towards achieving the objective: ***"Improving efficiency in programme coordination and management"*** of cMYP 2011-2015.

For all intents and purposes, these proposed objectives contained in the proposal will play a role in meeting the challenges on immunization that are raised in NHDP 2011-2015 and will entail executing activities with regard to the strengthening of technical capabilities in supplying healthcare services through the health system, in the health information system, in community interventions, in the communications strategy, in purchase and logistics chain management, and in accessibility to quality products in immunization services. In addition to meeting the challenges of the NHDP, this proposal will also contribute to surmounting the restrictions identified in cMYP 2011-2015.

This proposal will take over from the plan in current implementation, which extends up to the end of the

[16] National Health Development Plan 2011-2015

year in course.
Some of the activities planned in this proposal aim for the same results as those implemented in the current plan. This will seek to:

- Contribute to financing the operational costs of measles immunization monitoring campaigns, Mother-Child Health Weeks and African Vaccination Weeks (AVWs).

- Contribute to purchasing and distributing long-term insecticide-treated mosquito nets (ITNs) intended for mothers bringing their children for measles immunization;
- Strengthen the supply and supervision of complementary immunization activities by renovating health district vehicle fleets, ensuring maintenance and insurance policy payments;
- Finance the organization of the RED “Reach Every District” approach in low immunization coverage health districts;
- Purchase work tool kits composed of: mobile phone, megaphone, bicycle, umbrella, bibs, ankle boots, waterproof jacket, file-holders.

The latter two activities mentioned above are found in both the current HSS GAVI proposal and the GAVI Support component to Civil Society Organizations (CSO).

Other activities in this proposal, while not the same, are intended as supplements to those contained in the proposal currently under implementation. It is to be pointed out that, in addition to GAVI Alliance support, the Ministry of Public Health and the Fight against Aids has other Technical and Financial Partners supporting the “Health System Strengthening” component with regard to immunization. All these partners work in synergy towards contributing to the improvement of the population’s state of health.

3.2 a) Narrative description of programmatic activities

→ *Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.*

3.2 b) Logframe

→ *Please present a logframe for this proposal as Attachment 2.*

3.2 c) Evidence base and/or lessons learned

→ *Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide details of previous experience of implementing similar activities where available.*

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3.2 a) Narrative description of programme activities

The purpose of this proposal is to consolidate the national health system in general and the health system of the area of intervention in particular, so as to serve as a base for the improvement and continuing maintenance of programme performances and immunization services. (See purpose in the logframe and its alignment with the NHDP).

Objective 1: To strengthen capabilities for supplying and using quality immunization services

This objective aims to improve the supply and demand for immunization services by acting through the following areas:

Area 1.1: Community activities and services - performance, use and quality

- To multiply and distribute 6000 booklets for community health agents (at the proportion of 1 booklet for each of the 6000 CHAs)
- To multiply and distribute 735 DAGADAGA booklets on Community-Integrated Management of Childhood Diseases (C-IMCD) for community based organizations (at the proportion of 1 booklet for every community based organization).

Area 1.2: Strategic and operational planning

- To organize support missions to the executive teams of 19 health districts supported by GAVI HSS (In 2013: one mission combining 6 districts of rural Bujumbara and Bururi, in 2014: one mission combining 6 districts of Mwaro and Gitega; in 2015: one mission for 7 districts of Kayanza and Kirundo), with 4 persons in each case per district for analysis and micro-planning in the framework of the "reach every district" strategy, every year for the EPI and partners.

Area 1.3: Financial resources

- To participate in financing the operational costs of measles immunization campaign monitoring: 50% of operational costs for the 2015 monitoring campaign.
- To participate in financing the operational costs of local Polio Immunization Days for 2013, 2014 and 2015 in the proportion of 30% of operational costs.
- To participate in financing the operational costs of Mother-Child Health Weeks for 2013, 2014 and 2015 in the proportion of 24% of operational costs.
- To contribute to financing the organizational expenses of African Vaccination Week (AVW) in 2013, 2014 and 2015.

Area 1.4: Awareness-raising, communication and social mobilization

- To produce communication and social mobilization tools (micro-programmes on radio, educational films, image box, fold-outs…) to improve the demand and use for immunization services.
- To purchase equipment (montage computers, cameras, recorders, microphones...) to produce the communication tools for improving the demand and use for immunization services.
- To purchase and replenish consumables every year (cassettes, CDs, DVDs, diskettes) for the communication equipment to improve the demand and use for immunization services.
- To organize a one-day awareness-raising campaign on a six-monthly basis for social mobilization to support the "reach every district" strategy (at the rate of one session of 100 participants every six months, starting September 2013).
- To pay the transport expenses of 6000 community health agents (in the proportion of 2 agents for each of the 3000 hills) for 5 days during social mobilization in the framework of the "reach every district" strategy.
- To contribute to organizing the re-launching of the new rotavirus vaccine.

Area 1.5: Surveys, research and evaluation

- To organize 2 evaluation meetings of two days each on a six-monthly basis on vaccine management and quality for 45 managers starting in 2014.
- To contractually commit 223 Local Associations (LOAS) in the health center spheres of responsibility for 6 provinces supported by GAVI HSS to conduct community verification surveys on satisfaction levels in relation to immunization services for 2013.

Area 1.6: Purchase and logistic chain management

- To purchase 50 photovoltaic refrigerators for the sectarian and private health training courses in the third quarter of 2013.

Area 1.7: Health personnel

- To train and/or recycle 90 managers (at the proportion of 2 participants for each of the 45 health districts) in managing medicines, vaccines and laboratory consumables in 3 sessions of 30 participants each (each session lasting 5 days).
- To train, in 6 five-day sessions of 30 participants each: 45 health district head physicians and 135 multi-purpose health district supervisors on the "reach every district"/"reach every child" approach (In 2013: 2 sessions in the 4th quarter; in 2014: 2 sessions in the 2nd quarter and 2 others in the 4th quarter of the same year, with 5 days for each session).

- To train, in 2013, 10 National Rapid Intervention Team (ENIR) trainers on the new surveillance tools for diseases of epidemic potential (IDSR) in a 5-day session.
- To train 45 BDS and 17 BPS trainers on the new surveillance tools for diseases of epidemic potential (IDSR) in two 5-day sessions of 31 participants each during the 3rd and 4th quarters of

2013.

- To train HC heads in a 5-day district-level workshop on the surveillance of diseases of epidemic potential (a workshop lasting 5 days with 17 participants, held in each of the 22 districts during the 4th quarter of 2013 and in the 23 other districts during the 1st quarter of the year 2014).

Objective 2: To contractually commit peripheral health facilities and community-based organizations with a view to improving the performance of immunization services in districts with low immunization coverage rates

Area 2.1: Financial resources

- To contribute on a quarterly basis to pursuing the contractual commitment of 6 CBO management agencies for community interventions relating to immunization in the 6 provinces supported by GAVI HSS for 2013.
- To contractually commit 223 community-based organizations working in health center spheres of responsibility regarding the execution of the community package, covering delivery (distribution), referrals (recovery, abandonment, orientation) and integrated awareness-raising (family planning, immunization, malaria, tuberculosis and HIV) for 2013.

Area 2.2: Healthcare financing

- To contribute to purchasing the performance of 223 HCs through services related to the "fully vaccinated children" and "tetanus-vaccinated pregnant women" indicators for the year 2013 starting from the 2nd quarter.
- To contribute to the payment of quality bonuses for 223 health centers of the 19 GAVI HSS-supported BDS to improve the quality of immunization services for the year 2013 starting from the 2nd quarter.

Objective 3: To ensure access to vaccines and the rational management of the supply chain, logistics, and medical product and equipment safety.

Area 3.1: Material resources - infrastructure and products of prime necessity (among them, medical products and other products/technologies)

- To contribute to the purchase and distribution of 150 000 bed nets (in the proportion of 50 000 per year) treated with prolonged-action insecticide (ITNs) for the 19 BDS supported by GAVI in 2013, 2014 and 2015.
- To purchase 6000 work tool kits composed of:mobile telephone, megaphone, bicycle, raincoat, bibs, ankle-boots, waterproof jacket, file-holders (in the proportion of one kit for every CHA) in 2013.

Area 3.2: Purchase and logistic chain management

- To purchase 25 10 KVA generators in 2013 to support decentralization in vaccine management on the Health District level.
- To ensure cold chain maintenance in all 6 provinces of the GAVI HSS area of intervention on a quarterly basis starting 2014.
- To purchase a 40 KVA generator for the EPI in 2014.
- To purchase 13380 liters of petrol on a quarterly basis (in the proportion of 60L per health center per quarter) for the refrigerators of 223 health centers in the GAVi HSS area of intervention, starting 2014 up to 2015.
- To pay for a yearly fire insurance policy covering EPI depots.
- To purchase 19 double-cabin vans for supplies, supervision and health center complementary immunization activities by the Health District Offices of the provinces of Gitega (4 BDS), Bururi (3 BDS), Kayanza (3 BDS), Mwaro (2 BDS), rural Buja (3 BDS) and Kirundo (4 BDS) in 2013.
- To ensure the maintenance of the 19 double-cabin vans on a quarterly basis starting in the 4th quarter of 2013 up to the end of 2015.
- To purchase 4 double-cabin vans for the EPI to supervise immunization activities and monitor EPI target diseases.

- To pay for the insurance policy of the 19 double-cabin vans on a quarterly basis starting in the 4th quarter of 2013 up to the end of 2015.

Area 3.3: Infrastructures

- To replenish the stocks and rehabilitate the offices of the EPI also housing the HSS/GAVI management unit.
- To purchase syringe destroyers for the 223 health centers of the 19 GAVI-supported BDS in the 2nd quarter of 2014.

Objective 4: To strengthen the system of health information and M&E on community interventions

Area 4.1: Monitoring and documentation of community and government interventions

- To recruit a national consultant for the harmonization of data-gathering tools on the community level for one month.
- To organize a three-day workshop for 19 participants to prepare the HIS tools for gathering data from the community and the civil register.
- To contribute to the conduct of a KAP survey on EPI performances in the proportion of 18% of the total costs.
- To organize a 2-day national workshop for 50 participants to validate community-level data-gathering tools.

Area 4.2: Regular data gathering, analysis and processing

- To multiply and distribute 735 data-gathering tools a year revised by health centers.

Area 4.3: Health personnel

- To train the staff charged with the Health Information System on the HC level through the district management teams in the course of three 5-day workshops of 30 participants each regarding the revised data-gathering tools (2 persons per district = 90).
- To train two hundred providers from private health centers and hospitals in the management of biomedical waste in the course of five 5-day workshops with 40 participants per workshop.

Area 4.4: Surveys, research and evaluation

- To recruit two national consultants for 30 days to undertake a survey on immunization coverage in 2015.
- To pay the expenses of 10 local interviewers for 15 days with regard to the immunization coverage survey in 2015.

Area 4.5: Management and organization of establishments

- To recruit a national consultant for fifteen days to update the biomedical waste management plan.

Objective 5: To ensure programme management.

Area 4.5: Management and governance

- To ensure the bonus payments of the HSS/GAVI management unit and the salaries of management and administration experts in M&E and public procurement.
- To ensure the operation of the HSS/GAVI management unit.
- To organize quarterly monitoring missions on the conduct of interventions in the 6 GAVI-supported provinces.
- To purchase 4 vehicles for the HSS/GAVI management unit.
- To purchase 9 information technology kits to supplement the existing IT facilities of the HSS/GAVI management unit.
- To purchase 6 laptops for the HSS/GAVI management unit.
- To purchase 2 photocopiers for the HSS/GAVI management unit.
- To furnish the offices of the HSS/GAVI management unit.

- To hire an office to evaluate the performance of the HSS/GAVI R11 project technical implementation.
- To hire an office for the financial audit of the HSS/GAVI R11 project.

3.2 b) Logframe

The logframe of this proposal covers 5 objectives related respectively to the strengthening of immunization service availability and use, the contractualization of health services on the community level, the access and safety of immunization products, the strengthening of the HIS, and programme governance and management. The activities to be implemented for each objective are defined by service delivery area, and their surveillance will be ensured with the help of result indicators on effect and impact, such as are presented in the attached logframe.

3.2 c) Specific elements and/or lessons learned

- The integration of other interventions in mother and child health to immunization activities have strongly contributed to the rise in the demand and use of these services. Activities regularly integrated into vaccination campaigns are: the promotion of key family practices (exclusive breast-feeding, washing hands, the use of insecticide-treated bed nets), the removal of parasites with albendazole, and the use of vitamin A supplements. The integration of these interventions has proven more cost-effective in reducing child morbidity and mortality.
- The implementation of the “RED” approach has made it possible to improve routine immunization coverage rates and will be pursued to recover abandonments and strengthen ties between the immunization units and the community.
- Communication activities for implementation have regularly been conducted for both routine EPI and the introduction of new vaccines (Hib, Hep B, pneumococcus) with satisfactory results. These activities will be resumed during monitoring campaigns and during the introduction of new vaccines (rotavirus).
- The cost of the new vaccines introduced in routine EPI being increasingly on the rise, it is vital to control vaccine loss while ensuring safety and protecting beneficiaries, promoting the training and recycling of providers in their management. Vaccine use thus proves to be of capital importance and must be sustained.
- The purchase of the performance of healthcare facilities and CBOs has contributed to the improvement in health service quality, its performance, and the motivation of providers. This initiative will be sustained by this proposal.
- Immunization must rest on a stable health infrastructure and be supported by surveillance and monitoring. The logistics involved in the EPI require constant renovation to meet standards, at the same time taking account of the introduction of new vaccines. Material purchased in this area also contributes to the execution of interventions relating to other health programmes.

The organization of coordination and consultancy frameworks with the other intervening partners in the field has made it possible to prevent possible overlaps in HSS-GAVI project implementation.

3.3 Main Beneficiaries

→ Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.

TWO PAGES MAXIMUM

This project has to cover 19 health districts with low immunization coverage rates and no partners giving support to immunization services. These are located in 6 of the total 19 health provinces in the country.

These health districts are:

1. Rural Bujumbara province: Kabezu, Rushubi and Twibaga HDs
2. Bururi province: Rumonge, Bururi and Matana HDs
3. Gitega province: Mutaho, Ryansoro, Gitega and Kibuye HDs
4. Kayanza province:Gahombo, Kayanza and Musema HDs
5. Kirundo province:Vumbi, Busoni, Mukenke and Kirundo HDs
6. Mwaro province: Kibumbu and Fota HDs

The target population of this project is composed of all the children from 1 to 11 months old and all the women in fertile age in these health districts. No financial contribution shall be asked of the population of these HDs. The participation of CBOs aims to cover all the population categories of the different parts of this intervention area. The RED approach will be organized to favor all the population categories that are hard to reach and/or are subject to other barriers (cultural and religious). There are no population groups stigmatized, discriminated against and/or marginalized with regard to immunization in these areas.

4. Performance Monitoring and Evaluation
4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework *→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed template) as Attachment 4.*
4.2 a) M&E arrangements *→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.* 4.2 b) Strengthening M&E systems *→ Please describe the M&E systems strengthening activities to be funded through this proposal.*

THREE PAGES MAXIMUM

4.1 National M&E plan and performance framework

The national monitoring and evaluation plan, called *Cadre du Suivi et Evalation* (CSE) contained in NHDP 2011-2015 (Annex 3):

- makes a brief summary of the context and objectives of the NHDP;
- explains the factors justifying the demand for an M&E framework;
- presents the national and international frameworks conditioning the orientations of NHDP 2011-2015;
- presents the indicators selected for the monitoring and evaluation of NHDP 2011-2015;
- presents the objectives of NHDP 2011-2015 and specifies the targets of the present M&E framework;
- presents what it has been agreed to call the M&E frameworks (conceptual framework, strategic framework, logframe), the strategy projected with regard to these factors, and the synoptic table of the simplified plan (logframe);
- explains the data circuit resulting in the information from the indicators;
- specifies the institutional frameworks and mechanisms by which the M&E framework should be set up;
- proposes an action plan and a budget for the implementation of this M&E framework.

It was prepared by taking account of the strategic objectives and orientations of NHDP 2011-2015 with a Results-Oriented (ROM) approach. This framework makes it possible to appraise NHDP performances and objectives in relation to the results expected in terms of products, effects and impacts.
The performance framework for this proposal (Annex 4) includes four objectives and ten programme indicators, with five indicators responding to the first objective, two to the second, one to the third and two to the last. In addition, it includes two effect indicators and one impact indicator. These indicators are included for project performance monitoring during its implementation period, which extends from January 2013 to December 2015. This performance framework will make it possible to measure the achievement of results in relation to the targets set per indicator.

4.2. a) M&E modalities

The current national M&E system is fed by the health facilities (health centers and hospitals of first, second and third referral) and the data on community services by the HCs, through the healthcare promotion technicians coordinating the community agents in their spheres of responsibility. This reflects, above all, the monitoring indicators of the NHDP 2011-2015 M&E Plan, including the implementation data of this proposal. The data gathered from the organizations and community agents are consolidated together with public sector data from the HCs.

The data from the HCs and hospitals are gathered respectively by the responsible nurses and the person responsible for the Health Information System (HIS) in the healthcare facility, based on standard data-gathering records and report templates. They are compiled and processed on the level of the BDS and BPS by an agent charged with the HIS, and sent to the department of the National Health Information System (NHIS).

The project performance framework indicators that the country is submitting to GAVI are inspired by the National M&E Framework. They will be used in monitoring project implementation performance. The data-gathering tools to be used by the agents in implementation are those currently in the national M&E system.

The health data reporting circuit on the community and peripheral level, on the intermediate level, and, subsequently, on the national level, will be assumed by the agents involved in project implementation to draw up reports on the results of HSS support.
The district executive teams meet monthly to analyze HIS reports from the HCs so as to ensure quality in healthcare facility reporting. The provincial committees on statistical data verification verify the PBF indicators, among them two indicators relating to immunization (fully immunized children and women vaccinated against TT). These reports are transmitted afterwards to the central level, where they are analyzed by NHIS in collaboration with those responsible for monitoring and evaluating health programmes.

The inverse circuit, from the central to the intermediate level, and then to the peripheral and community level, adopted
to control quality in reporting, shall likewise be used among the modalities of project
execution monitoring.
NHIS prepares statistical yearbooks that are submitted for analysis to the key actors on all levels before being presented for validation to the specialized CPSD M&E group.
The preparation of the implementation reports on the present proposal will follow the abovementioned circuit, and approval will be ensured by the CPSD before they are sent to the GAVI Alliance.
It is nonetheless useful to reinforce the capabilities of the GAVI HSS Management Unit with the assistance of an M&E expert. This latter will be called upon for proactive help in the quality of the project report components and timely submission in relation to the performance framework deadlines.

4.2 b) M&E systems strengthening

The national M&E system was assessed on the occasion of NHDP 2006-2010 evaluation, the report on which was published in July 2010. The weaknesses of the M&E system found in the course of this evaluation are as follows:
* Fragmented health information system;
* Lack of exhaustive reporting in healthcare service data-gathering;
* Unreliable databases due to missing data, particularly in the areas of infrastructure, equipment, budget, human resources, medicines and consumables;
* Data coming from inventories or surveys not connected to the health information system for operating purposes ;
* Parallel data-gathering by vertical programmes that consequently escape NHIS control.

In addition to the weaknesses found in the NHDP 2006-2010 evaluation, the situational analysis done in the framework of preparing NHDP 2011-2015 revealed that data on the community level are not systematically gathered and integrated into the national health information system.

NHDP 2011-2015 has defined its strategic thrusts, inspiring the National Health Information System to define corrective measures for the weaknesses mentioned above, reflected in its strategic plan for 2011-2015.

The implementation of the Health Information System's strategic plan benefits from the support of different partners, such as Belgian Technical Cooperation (CTB), UNICEF, WHO, GAVI Alliance, USAID, and others contributing to the multiplication and distribution of data-gathering tools.

The new data-gathering tools will make it possible to post data by age and sex, with a view to ensuring equitable access to immunization services.

In the framework of this proposal, the support to strengthen the M&E system requested from the GAVI Alliance amounts to **US$ 325 321** and essentially bears on the harmonization of data-gathering tools on the community level, the multiplication and distribution of HC data-gathering tools, the strengthening of NHIS personnel capabilities on all health system levels, and the technical assistance of an M&E expert.

The funds requested will make it possible to conduct the activities projected to strengthen the M&E system, set forth in objectives 4 and 5. These eight activities falling under the fourth objective will contribute to strengthening M&E on both the community level, as regards data-gathering, and on the level of the routine Health Information System.

The following activities fall under objective 4:

- To recruit a national consultant for the harmonization of data-gathering tools on the community level for a period of one month;
- To organize a three-day workshop for 10 participants to prepare HIS tools for gathering data from the community and the civil register.
- To organize a 2-day national workshop for 50 participants to validate community-level data-gathering tools;
- To multiply and distribute 2,205 (735 per year) copies of data-gathering tools a year revised by health centers;
- To train BDS personnel charged with the Health Information System (routine HIS and community HIS) for 5 days in supervising HCs and CBOs regarding data-gathering (2 persons for each of the 19 GAVI-supported districts);
- To recruit two national consultants for 30 days to undertake a survey on immunization coverage in 2015;
- To pay the expenses of local interviewers for the immunization coverage survey of 2015;
- To contribute to the conduct of a KAP study on routine EPI performance.

As regards objective 5, the plan is to recruit an M&E expert who will not only support the management unit in monitoring and evaluating project activities, but also contribute to strengthening the M&E system.

Implementation of these activities will complement the efforts of other partners aimed at ensuring adequate monitoring of interventions on all health system levels, including the community level, which to date is the least integrated.

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

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5.1 Detailed work plan and budget

Preparation of the detailed work plan and budget has observed the coherence of the numbering used in the other documents of this proposal, to wit: the logframe and the performance framework.

The chronology for activities and budget is organized in quarters and the timeline extends from January 2013 to December 2015. The unit costs for each activity are drawn from budget hypotheses for the first year, while an estimated inflation rate of 9% (Annex 17) has been applied to the second and third year. The estimate of these unit costs was based on the budgeting of similar activities recently conducted. The determination of the honoraria and per diems applied in this proposal is based on Order no. 120/VP1VP2/02 of 03 February 2006, setting the scale and modalities of granting official mission orders and expenses as per the presidential decree of 2006 (Annex 18). The budgeting currency used is the US dollar and the mean exchange rate is the rate applied by the BRB for FY 2011.

The detailed budget shows all the execution units, cost categories and funding sources of this proposal, which is the GAVI Alliance.

5.2 Analysis of financial gaps

Analysis of the financial gaps was conducted per HSS pillar. The source used for this analysis is the EPI cMYP document for 2011-2015. Determined for each pillar were: needs (Section A of the file on work plan and budget of “HSS Gap Analysis 1 to 6”), the current and projected resources of the national programme (section B) and the current and planned external resources other than those of the GAVI Alliance (Section C). Since the structure of the cMYP components does not tally with the six HSS pillars, the interventions in these different components have been reclassified under different pillars. The table in Annex 19 sets forth the detailed classification of cMYP 2011-2015 interventions in terms of HSS pillars.

- ✓ **Service delivery**

The amounts necessary to cover needs for this pillar are estimated at US$ 56 225 748 for 2013-2015. The remaining financial gap to be met is in the amount of US$ 44 677 535, knowing that available funds amount to US$ 11 548 213, contributed by the Government, the WHO and UNICEF.

- ✓ **Healthcare professionals**

The sums necessary to cover needs in terms of healthcare professionals amount to US$ 9 502 942, with the financial gap for this pillar amounting to US$ 8 205 292. Available funding amounts to US$ 1 297 650 for 2013-2015, coming from UNICEF and the Government.

- ✓ **Information and M&E**

The amounts necessary to cover needs in EPI information and M&E total US$ 1 672 576. The financial gap in this pillar totals US$ 1 310 576, available funds amounting to US$ 362 000, solely given by UNICEF.

- ✓ **Financial resources**

The needs to be covered in 2013-2015 for financial resources are in the amount of US$ 8 603 304. The financial gap for this component totals US$ 787 773, while available funding is at US$ 7 815 531. This entire amount is given by the Government.

- ✓ **Administration of health services and governance**

The needs in this pillar amount to a total of US$ 438 443. The financial gap amounts to US$ 412 843, while available funding totals US$ 25 600, financed by the Government.

- ✓ **Infrastructures**

A total amount of US$ 3 164 837 is necessary to cover infrastructure needs for 2011-2015. While the financial gap amounts to US$ 3 121 342, available funding totals US$ 43 495, provided by UNICEF and the Government.

5.3 Information accounting for and justifying the proposed budget

The preparation of this proposal has ensured technical adaptation and the observance of priorities by adopting cMYP 2011-2015 and NHDP 2011-2015, validated by the CPSD, as references for the interventions to implement. The HSS-GAVI project currently under implementation covers twelve health districts. It has posted notable performances in terms of immunization coverage in the majority of health districts. It is thus convenient to consolidate the achievements in these districts by implementing activities that have proven effective in districts of low immunization coverage without development partners. The expansion will cover seven new health districts, adding up to a total of 19 health districts in the future area of intervention.

As regards efficiency, it is proposed that future support pursue the same activities as the current HSS project and CSO support component by placing specific emphasis on immunization, in particular, by intensifying community participation to improve the demand and use for immunization services. The results on current record in terms of immunization coverage demonstrate the efficiency of the implemented activities that the proposal seeks to pursue and expand. The activities found in this proposal are coherent with the interventions included in cMYP 2011-2015. The CPSD has seen to it that objectives are in harmony with the strategic thrusts of NHDP 2011-2015.

This proposal was developed in the context of the reforms underway in the Ministry of Health and the Fight against AIDS aimed at enhancing the efficiency of activities; to wit: integration, decentralization, performance-based funding, etc. These approaches seek to obtain expected results at the least cost. The maximum number of activities will be conducted by community level health facilities under the supervision of executive district teams. The majority of the interventions will be conducted by the operational level (BDSs, HCs and CBOs), while the central and intermediate level will ensure additional regulation. The unit costs used in the budget are set forth in detail in the file contained in Annex 5 and refer to the costs of interventions recently implemented, and ordinances and decrees currently applicable in the country.

The financing requested will make it possible to obtain results that would not be possible otherwise, since it would be necessary to continue supporting the twelve districts currently covered on the one hand, and the seven more that have no other funding in the HSS area with regard to immunization on the other. Duplication will be avoided through different CPSD meetings on the national and intermediate levels.

The main expense items of this proposal are: service delivery in the proportion of 44%, and the financial resources, which take up 39% of the overall proposal budget. The service delivery pillar essentially consists of expenses related to awareness-raising and community mobilization in favor of immunization, the organization of RED campaigns in different health districts, the purchase of teaching equipment and material, the purchase of vehicles and communication tools, social mobilization expenses and the contractualization of CBOs for community-based activities. As regards the financial resources item occupying second place, these essentially concern activities in relation to performance-based funding on the health center level, campaigns and days of mobilization, mass immunization, and the organization of weeks dedicated to mother-child health. This expense item is considered very important because the activities related to it are aimed at staff motivation, service quality, and the improvement of the performance and function of health facilities on the provincial and district level. Moreover, performance-based funding is one of the strategies of national policy and of NHDP 2011-2015 (in its fourth strategic thrust), currently scaled up. The two main expense items for this future GAVI HSS project are aimed at improving the performance of the national immunization programme in terms of results.

Human resources costs are of two types; first, there are performance bonuses to be attributed to HC and CBO staff in the area of intervention and civil servants assigned to the project management unit, and the salaries that will be given to the three experts recruited to support the management unit.

These bonuses have been instituted on the basis of the national strategy with regard to contractualization (PBF) and refer to the manual of PBF management procedures (Annex 20).

In addition, HCs and CBOs are evaluated by the Provincial Verification and Validation Committees for the quantity indicators every month and for the quality indicators every quarter. As regards the project management unit, its evaluation will be ensured by the independent commission on performance evaluation of the Technical Commission/PBF, which has been appointed by the Ministry of Public Health and the Fight against AIDS. This latter will sign a performance contract with the project management unit, like the HCs and CBOs that sign contracts with the head physicians of the districts within their province.

Experts' salaries are based on the salaries attributed to the experts of other MSPLS partners for similar projects (World Bank).

Upon the termination of the support proposed, recurrent costs will be assumed by the Government and its partners.

The overall budget of the present proposal will appear in the public treasury. Moreover, public sector financing in the area of immunization will figure in the table of medium-term expenses. Other "institutional" costs were established on the basis of costs previously applied. At the end of the project, recurrent costs will be assumed by the Government and its partners.

6. Implementation Arrangements, Capacities, and Programme Oversight

6.1 a) Lead Implementementers (LI)

-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.

→ Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives.

Lead Implementer:	Ministry of Public Health and the Fight against AIDS, through its HSS-GAVI management unit
Objective(s):	**Objective 1:** To strengthen capabilities for supplying and using quality immunization services **Objective 2:** To contractually commit peripheral health facilities and community-based organizations with a view to improving the performance of immunization units in districts with low immunization coverage rates **Objective 3:** To ensure access to vaccines and the rational management of the supply chain, logistics, and medical product and equipment safety. **Objective 4:** To strengthen the Health Information System and M&E for community interventions **Objective 5:** To ensure programme management

→ *Description of the Lead Implementer's technical, managerial and financial capabilities.*

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The coordination and implementation of the HSS-GAVI project "KARADIRIDIMBA" will be entrusted to the management unit of the current HSS-GAVI project underway. This unit benefits from a 5-year experience in project management. This team is composed of:

1) A Coordinator, Master in Health Economics;
2) An Assistant Coordinator, Physician;
3) An Assistant Clerk, BA graduate in project management;
4) An Accountant with 2 years of accounting
5) A Secretary-Cashier holding technical diploma in Secretarial Management

This team will be strengthened by the recruitment of three other experts in financial management, M&E and procurement.

The existing unit has already implemented management tools, which are: the manual of administrative, financial and accounting management procedures, a SAGE SAARI accounting software, scorecards for cartage management, IT and office equipment, telephones, a fax and an internet connection. The management unit avails of two SUVs for the supervision of the HSS-GAVI project intervention area.

Lead Implementer:	
Objective(s):	1) 2) 3) etc.

→ *Description of the Lead Implementer's technical, managerial and financial capabilities.*
HALF-PAGE MAXIMUM The implementing entity will be the Ministry of Public Health and the Fight against AIDS, for which the management unit of the "KARADIRIDIMBA" project will ensure technical coordination. This latter will organize coordination meetings between managers of BPSs, BDSs and CBO coordination agencies in the project intervention area on the implementation of activities on a six-monthly basis to ensure performance and resolve any possible problems encountered by operatives in the field. It will also participate actively in quarterly meetings organized by the General Directorate of Health Services and the Fight against AIDS to coordinate the implementation of health policies, strategies and programmes on the level of all the BDSs and BPSs in the country. In addition, the management unit will participate in the coordination meetings of partners organized monthly on the level of BDSs, and quarterly on the level of the BPSs, so as to harmonize interventions and create synergy between the different public and community agents. The establishment of a Consultation Framework of Partners for Health and Development on the provincial level that will coordinate the implementation of health sector interventions in the provinces, including those of the "KARADIRIDIMBA" project, is envisioned for the immediate future.

6.1 b) Coordination between and among implementers
→ *Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.*
ONE PAGE MAXIMUM The implementing entity will be the Ministry of Public Health and the Fight against AIDS, for which the management unit of the "KARADIRIDIMBA! project, which will depend directly on the Directorate General of Health Services and the Fight against AIDS, will ensure technical coordination. This latter will organize coordination meetings between managers of BPSs, BDSs and CBO coordination agencies in the project intervention area on the implementation of activities on a six-monthly basis to ensure performance and resolve any possible problems encountered by operatives in the field. It will also participate actively in quarterly meetings organized by the General Directorate of Health Services and the Fight against AIDS to coordinate the implementation of health policies, strategies and programmes on the level of all the BDSs and BPSs in the country. In addition, the management unit will participate in the coordination meetings of partners organized monthly on the level of BDSs, and quarterly on the level of the BPSs, so as to harmonize interventions and create synergy between the different public and community agents. The establishment of a Consultation Framework of Partners for Health and Development on the provincial level that will coordinate the implementation of health sector interventions in the provinces, including those of the "KARADIRIDIMBA" project, is envisioned for the immediate future.

6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*		
(i) Will other departments, institutions or bodies be involved in implementation as Sub-Implementers?	○ Yes	*→ go to section 6.1 c) (iii) and 6.1 c) (iv)*
	◉ No	*→ go to section 6.1 c) (ii)*
(ii) If no, why not?		
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(iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe: • The roles and responsibilities to be fulfilled; • Past implementation experience; • Geographic coverage and a summary of the technical scope; • Challenges that could affect performance and mitigation strategies to address these challenges.		
TWO PAGES MAXIMUM		
iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, explain why.		
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6.1 d) Strengthening implementation capacity

(a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.

→ Please refer to the Strengthening Implementation Capacity information note for further background and detail.

Management and/or technical assistance **objective**	Management and/or technical assistance **activity**	**Intended beneficiary** of management and/or technical assistance	Estimated timeline	Estimated cost *→ same as proposal currency*
• To strengthen the capabilities of the "KARADIRI DIMBA" project management unit in financial management, M&E and procurement.	To recruit and pay experts in financial management, M&E and procurement	Project management unit	3 yrs	US$ 270 000
• To strengthen executive team capabilities on the BPS and BDS level of the HSS-GAVI intervention area in financial management, M&E and procurement.	• To organize technical support missions to BPS and BDS executive teams.	BPS and BDS executive teams	3 yrs	US$ 72 196

(b) Describe the process used to identify the assistance needs listed in the above table.

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In the course of preparing this project, the technical committee analyzed the profiles needed for efficient project implementation and contrasted them with the competencies currently existing in the HSS/GAVI project management unit. The committee found that the management unit needs to be strengthened in the areas of financial management, M&E and procurement. The technical committee has proposed to recruit experts in the abovementioned areas, the cost of which (salaries, operating expenses, BPS and BDS strengthening mission expenses) will fall upon the support requested from GAVI through the "KARADIRIDIMBA" project. This recruitment, like the other project activities, has been validated by the CPSD.

(c) If no request for technical assistance is included in the proposal, provide a justification below.

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6.2 Financial management arrangements

➔ *Please describe:*

a) The proposed financial management mechanism for this proposal;

b) The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.

c) Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.

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a) The mechanisms of financial management suggested for this proposal

There is a memorandum jointly signed by the Government of Burundi (represented by the Minister of Finance and the Minister of Public Health and the Fight against Aids) and the GAVI Alliance (represented by its Chief Executive Officer) dated 10 November 2010. This document defines the conditions and procedures of financial management for all current and future GAVI subsidies in favor of the Government of the Republic of Burundi, including: Immunization Service Support (ISS), Health System Strengthening (HSS), support for Civil Society Organizations (OSCs) and all future subsidies launched for New Vaccine Support (NVS).

All the financial management procedures described in this proposal are based on the abovementioned Memorandum and remain in force.

All funding for the present proposal will be subject to the General Regulations on the Management of Public Budgets and will be integrated into the national budget of the Government of Burundi, within a "budget for special allocation" (Section 3 of the General Regulations on the Management of Public Budgets). All the HSS funds for this proposal will thus be subject to the same rules and procedures as all the funds administered by the Public Treasury, with their use subject to the reservations of the exceptions envisioned in the provisions regarding "budgets for special allocation". These GAVI HSS funds will be paid into a sub-account of the treasury opened at the Central Bank and will be separated from the other funds administered by the Public Treasury. It must be noted that this sub-account will also serve for other programmes funded by GAVI, the most significant being ISS. Each programme will be subject to a separate balance.

b) **Financial management processes and systems**

- **Planning and budgeting**

HSS budgets will be prepared annually and staged on a quarterly basis. The annual and quarterly action plans budgeted will be presented to the CPSD for approval before the project budget is integrated into the General State Budget and before the funds from the pertinent Treasury sub-account are unblocked. The budgeted action plan must be sent to all the members of the CPSD at least two weeks before the date of the quarterly meeting.

- **Finance (fund management and disbursement)**

The HSS funds will be transferred to the account of the HSS-GAVI project opened at the Commercial Bank of Burundi (BANCOBU) every six months, upon authorization from the Ministry of Public Health and the Fight against AIDS and the Ministry of Finance. The funds will be unblocked from the Treasury sub-account by the signatures of both the Minister of Finance and the Minister of Public Health and the Fight against AIDS.
The HSS funds may be implemented from the above account following the written authorization of the Minister of Public Health and the Fight against AIDS with the signature of both the GAVI-HSS Project Coordinator and the Office Director of the Ministry of Public Health and the Fight against AIDS, whose missions are currently assured by the Permanent Secretary.

- **Accounting and financial reporting**

As regards “KARADIRIDIMBA” project management, accounting shall be kept with the help of the accounting software “SAGE SAARI”, which is being used to date in the current HSS project. This software enables the project to:
- easily generate accounting ledgers and the accounting plan;
- ensure budget, stock, invoicing, human resource and fixed asset management;
- edit accounting statements;
- establish wages.

The financial report on HSS expenses, presented as required by the Framework Law on Public Finance, shall be submitted to the CPSD every quarter and at the end of the programme year.
A full financial report covering the entire programme year (i.e., the financial year), as well as any additional period that the MSPLS has decided to include, shall be submitted to the GAVI Alliance, along with an Annual Status Report (ASR) for the year’s programme from the Government of Burundi. This financial report must be approved by the CPSD, without the need for a certificate by an external auditing office.

- **Internal control and auditing**

As stipulated in the abovementioned Memorandum, expenses with regard to the funds of the HSS “KARADIRIDIMBA” project will be subject to the control of the Court of Auditors, the highest auditing institution of the Government of Burundi, and the public finance management inspection corps (General State Inspection). As regards internal audit, the internal auditing unit of the Ministry of Public Health and the Fight against AIDS will be asked for help and audits will be conducted at need.

- **Supply**

Supplies shall be secured in accordance with the law on public procurement of the Government of Burundi (adopted on 2 February 2002). In any case, the project may route certain specific orders through UNICEF if its supply circuit and price/quality ratio present comparative advantages. It is to be pointed out that all project goods and services are exempt from taxes and customs duties.

- **Asset management**

The funds will be transferred to the Bank of the Republic of Burundi (BRB) by the GAVI Alliance and will afterwards be sent to a commercial bank (BANCOBU) that agrees to generate annual interests following negotiations. These interests will be added to the balance at the end of the financial year and reprogrammed into the budget of the annual action plan for the following financial year approved by the CPSD. In addition to the mechanisms of efficient cartage, asset and existing stock management, management is ensured through the help of the SAGE SAARI software. This will be continued during the implementation of the “KARDIRIDIMBA” project.

- **External audit**

Apart from the inspections conducted by the Court of Auditors and the public finance management inspection corps, the HSS programme shall be subject to yearly external audits ensured by an independent auditing office, as described in Section 3 (Management provisions regarding existing HSS funds) above. The audit reports will be submitted to the CPSD and to GAVI, at the latest, within the 6 months following the end of the financial year under consideration.

Details in relation to the process and system of financial management for HSS-GAVI funds are found in the Memorandum on the financial management of programmes funded by GAVI in favor of Burundi (Annex 21).

6.3 Governance and oversight arrangements

➔ *Please describe:*

a) *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);*

b) The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;

c) Plans (where appropriate) to strengthen governance and oversight;

d) Technical Assistance (TA) requirements to enhance the above governance processes.

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a) The CPSD, which has incorporated the ICC, is the only committee responsible for the governance of GAVI HSS support. This committee will ensure coordination for the entire HSS-GAVI project management process and will benefit from the expertise of the specialized groups on finance and M&E called upon to give their opinion on the important project documents, such as the budgeted action plans, the financial reports, the annual status reports and the M&E reports. Every year, the CPSD organizes field visits for the annual joint review of all agents intervening in the health sector. Project achievements are reviewed through this mechanism. The roles of the CPSD described here are indeed aligned with GAVI directives to the extent that the GAVI-Government of Burundi Memorandum in force indicates that budgeted action plans and HSS-GAVI annual status reports have to be approved by the CPSD.

b) To better coordinate the activities of the GAVI HSS support applied for with those of other health system strengthening programmes, a calendar of yearly CPSD activities is presented for approval by the CPSD secretariat at the beginning of every year. All those in charge of programme implementation are invited to present their budgeted action plans and their execution reports before the CPSD in this calendar. It is in this framework that the management unit of the “KARADIRIDIMBA” project will present its plans and evaluation reports to the CPSD. The budgeted action plans of the various civil society organizations intervening in the health sector are consolidated through the presentations made by the Department of Health Promotion, Hygiene and Sanitation (DPSHA).

c) The country has not projected for the preparation of plans to strengthen governance and the strategic monitoring of the future HSS GAVI support since the CPSD mechanisms of operation ensure governance as well as the efficient strategic monitoring of the implementation of NHDP 2011-2015 and the projects stemming from it.

d) No technical assistance is requested to strengthen governance and strategic monitoring in the framework of this support.

7. Risks and Unintended Consequences	
7.1 Major risks ➔ *Please describe any major "internal" risks (within the control of those managing the implementation of the HSS support) and "external" risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.*	
Risks	**Mitigating strategies**
Internal risks: 1. Financial misappropriation (fraud and/or corruption) 2. Turnover of project managers on the management unit, EPI and operational levels.	1. Implementation, management control, manual of public finance management procedures. 2. Improvement of working conditions to stabilize the managers involved in the project (bonuses, means of operation, training supervision, on-the-job training...)
External risks: 1. Delay in fund transfers 2. Administrative red tape in the disbursement of funds from the central bank to the GAVI-HSS project account. 3. Aggravation of the financial crisis followed by a possible funding shutdown from GAVI and/or partners involved in the activities of the immunization programme 4. Political instability leading to general insecurity	1. Shorten the timeline for the analysis of dossiers by the GAVI Secretariat by means of the independent review committee. 2. Streamline administrative procedures for fund disbursement on the level of the MSPLS and Finance. 3. Not applicable 4. Not applicable
7.2 Unintended consequences ➔ *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.*	
HALF-PAGE MAXIMUM Based on experience from the GAVI Project in course, no unintended consequences likely to arise have been observed to date from proposal implementation.	

Mandatory Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
1	National policy, national strategy, or other documents attached to this proposal, which highlight strategic HSS interventions (NHP 2005-2015 and NHDP 2011-2015)	✓
2	Logframe	✓
3	National M&E Plan	✓
4	Performance Framework	✓
5	Financial gap analysis, detailed work plan and detailed budget	✓

Optional Attachments → *Please tick when the attachment is included*		
No.	*Attachment*	✓
6	Communiqué by the CCM calling for proposals from public, private and association actors dated 26 August 2011 (hard copy)	✓
7	Minutes of the CCM General Meeting on 26 July 2011 regarding agreement to prepare and submit the proposal (hard copy)	✓
8	Minutes of the ordinary meeting of the CPSD on 23 September 2011	✓
9	Letter of appointment of committees to formulate R11 proposals dated 26 August 2011 (hard copy)	✓
10	Minutes of the CCM General Meeting held to validate the calendar of proposal preparation stages (hard copy)	✓
11	Minutes of the CPSD meeting of 23.09.11	✓
12	Minutes of the CPSD meeting of 28 October 2011	✓
13	Presentation of the HSS-GAVI R11 proposal to the CPSD at its session of 2 March 2012	✓
14	Budget Law establishing national payment schedules and budgets	✓
15	CPSD Terms of Reference	✓
16	Minutes of CPSD meeting of 11 May 2011 to approve cMYP 2011-2015	✓
17	Letter on macro-economic framework 2012-2014 of the Republic of Burundi	✓
18	Order no. 120/VP1VP2/02 dated 03 February 2006 setting the scale and modalities of granting official mission orders and expenses (hard copy)	✓
19	Table No. 1: Classification of cMYP 2011-2015 interventions into HSS pillars.	✓
20	Manual of PBF management procedures	✓
21	Memorandum on the financial management of programmes financed by GAVI in favor of Burundi	✓
22	MTEF 2011-2013	✓
23	NHDP 2006-2010	✓
24	JRF 2009-2010	✓
25	cMYP 2011-2015	✓
26	MAPPING	✓
27	NHDP 2006-2010 EVALUATION REPORT	✓
28	ASR 2007-2010 (see GAVI Alliance website)	✓
29	NHIS STRATEGIC PLAN	✓
30	Validation of the HSS-GAVI R11 proposal by the CPSD in its session of 26 March 2012	✓
31	Demographic and Health Survey of Burundi (EDSB) 2010	✓