Health Systems Funding Platform (HSFP)

Health System 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 consists of 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 complete this form.

Part A - Summary of Support Requested and Applicant Information

Applicant:	***MINISTRY OF PUBLIC HEALTH AND POPULATION* (MPHP)**			
Country:	***REPUBLIC OF HAITI***			
WHO Region:	***AMERICAS***			
Proposal title:	**Strengthening of immunization services in Haiti**			
Proposed start date:	**January 2013**			
Duration of support requested:	**3 years**			
Funding request:	**Amount requested from GAVI:**	**3.3 MM**	**Amount requested from the Global Fund:**	**---------**
Currency:	◉ USD		○ EUR	

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

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The Government of the Republic of Haiti has made a request for financial support from GAVI for its program on strengthening the healthcare system (GAVI-HSS).

This support is requested at a time when the Ministry of Health is building its structural framework that should ensure the strengthening of its leadership. In fact, the MPHP has just developed **a new health policy** based on which it has brought out **a new organizational framework**. Meanwhile, it has just published a **Reference System for Competencies and Employment** which will help streamline the management of staff within the MPHP.

In line with the measures undertaken, the Ministry has organized, in the second quarter of 2012, **the general state of the healthcare system** whose results have contributed to the process of development of the **Master Plan of the MPHP** to be operational over the 2012-2011 time period. This restructuring also covers the organization of service provisions with a focus on **recruitment, training and progressive deployment of a new generation of multi-purpose healthcare workers** that will ensure access for all segments of the population, especially those living in difficult-to-access areas, with a quality essential package of basic health services.

While the health system is being revamped and strengthened structurally, the National Immunization Program focuses on the continuous elimination of measles, rubella, congenital rubella syndrome and the eradication of polio across the country. Also, in order to be certified that it is free of the RR/CRS viruses, the country has started the process of **documentation and verification for the elimination of RR/CRS.**

While the healthcare system is being revamped and strengthened structurally, the National Immunization Program has developed its Comprehensive Multi-year Plan (cMYP) for 2011-2015. This plan takes into account the continuation of the elimination of measles, rubella / CRS as well as the eradication of polio across the country. Additionally, the program has a plan to strengthen the cold chain at all levels and is currently being implemented. In order to be certified that it is free of RR/CRS viruses, the country has started the process of **documentation and verification for the elimination of RR/CRS.**

To this end, within the perspective of the Intensive Activities for Child Health held in 2012, it has vaccinated more than 95% of children aged 9 months to 9 years against measles, rubella /CRS and the same percentage of children aged 6 months to 9 years against polio. These IACH were organized with an integration perspective which helped administer a dose of Vitamin A to children aged 6 months to 9 years and a dose of albendazole to children aged 2-9 years.

In line with these initiatives, the National Program has developed and started the implementation of the Comprehensive Multi-Year Plan (cMYP) for 2011-2015 and its plan for strengthening the cold chains at all levels.

At the operational level, it highlights the outreach immunization services conducted at 36 low-coverage districts through the implementation of the RED approach (Reach Every District - Reaching Every Municipality), which has significantly contributed to the coverage of children under 1 year-old with 85% DTP3 in 2011.

However, it is important to note that the national program continues to face challenges that hinder its effectiveness and efficiency. Indeed, these challenges are related to program management, system information (which does not allow, among other things, the screening and reduction of dropouts), the lack of human resources at all levels, and the poor capacity of the program to implement advanced strategies at the national level. In addition, **the daily provision of immunization services in health institutions** is not standardized and therefore **the monitoring** of activities should be strengthened.

In this context, the Health Services Strengthening plan is a timely opportunity to assist the Ministry in strengthening the national immunization program and, at the same time, the integrated delivery of basic health services whose results would help the country in the realization of the MDGs for 2015.

The HSS will add on to the ongoing efforts of the MPHP to deal with healthcare problems of countries characterized by health indicators that are considered the highest in the region. The move towards an improvement in the health status of the population is very slow. Indeed, the newborn, infant and child, and maternal mortality rates related to issues such as the prevalence of certain infectious diseases, limited access to health services, the unequal distribution of health resources, low levels of basic sanitation, and a very low level of health education are challenges which the HSS plan will help to face.

The goal of GAVI-HSS support is to contribute to improving the performance of the National Immunization Program through, on one hand, the strengthening of program management at the national, district and local levels, and on the other, the increase in universal access to immunization services incorporating the essential package features of basic healthcare services.

Objectives:
The proposed objectives summarize the major areas of intervention by which the MPHP intends to achieve the strengthening of this program and, at the same time, accomplish these basic healthcare services. These are:

1. Improve the ability for programming and monitoring of the Program and immunization services at the three levels of the system.
2. Strengthen the information system of the Expanded Program on Immunization.
3. Strengthening the access and organization of immunization services.

The strategy primarily consists of extending immunization services through a new joint provision of institutional and community services. In this context, the strengthening of immunization services should contribute to the strengthening of other services and the healthcare system as a whole.

The following will benefit from this strengthening: maternal and child healthcare services – by improving the core functions such as planning, monitoring, evaluation, supervision, health education and staff training.

In other words, the HSS proposal aims to strengthen the regular program by ensuring its viability through the strengthening and systematic planning of activities as well as (integrated) training supervision for the monitoring and evaluation of plans developed at different levels of the system. It will contribute to a certain level of modernization of the health information system through the leveraging of new technologies to improve the accessibility of the immunization program and to reduce the dropout rates.

The proposal will also provide the National Immunization Program opportunities to reduce social inequalities in basic healthcare and particularly with regards to immunization.

Children, mothers, and women of childbearing age are the main beneficiaries of the HSS Project. In addition to these, healthcare personnel, health institutions and, in general, the national healthcare system will benefit.

It is important to note the perfect correlation of the HSS Project with the Comprehensive Multi-Year Plan (cMYP) for 2011-2015 and with the broad guidelines for strengthening the regular immunization program, which is a component of the cMYP. In fact, the HSS plan fills the gap in terms of resources and the means necessary for the operationalization of the cMYP. Finally, it will help implement the principle of integration advocated by the National Health Authority in its new policy in a more systematic manner.

Measures are to be taken in advance to increase sustainable immunization coverage, lower dropout rates, improve the management and organization of structures, and involve the rationalization and systematization of service delivery, quality assurance and the integration and effectiveness of immunization services.

In this process, the MPHP will rely on the Inter-Agency Coordinating Committee (ICC), whose mission, composition and functioning will soon be formalized through a ministerial decree.

Partners who are full-time members of the ICC have all participated actively in the process of developing this proposal. They are all engaged in the ongoing activities to strengthen the routine immunization program on a sustainable basis.

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.

• 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, marginalized or otherwise disadvantaged populations. Describe the leadership, management, coordination, and oversight of the proposal development process.

ONE PAGE MAXIMUM

At the outset, it should be noted that the drafting process of the proposal for the Project to Strengthen Health Services began with the initiative of 2007; at the end of this, a proposal in this area was submitted to GAVI. The Ministry held that this new approach should take into account the results of the work realized in collaboration with various sectors. The MPHP recommended that the lessons learned from the first attempt be used to ensure a positive response to this new request addressed to GAVI.

In short, to prepare this proposal, the Ministry has received technical support from the Pan-American Health Organization / World Health Organization (PAHO/WHO). To facilitate the work in the given time frame (less than 2 months), PAHO/WHO recruited an international consultant with experience in preparing such proposals for other countries. At the end of discussions leading to the selection of priority areas of intervention and the general and specific objectives of the project, the Lead Consultant was joined by two other Consultants -one each from WHO and GAVI- who, after studying the work already executed and the terms for project development, made recommendations on the form and content of the proposal.

In general, the proposal drafting process followed the steps mentioned below:

1. Studying documentation of the proposal developed in 2007, the National Healthcare Policy (July 2012), the National Strategic Plan for the Healthcare Sector Reform (2005-2010), the Comprehensive Multi-year Plan for Immunization (2011-2015), the Service Offer Report in the Haitian National Health System (December 2007), the Internal Evaluation of the Expanded Program on Immunization (September 2008), the mid-term Evaluation of the Project to support the Expanded Program on Immunization in Haiti (September 2011), amongst others.
2. Meeting with the MPHP authorities, the National Directorate of the Expanded Program on Immunization, PAHO/WHO, UNICEF and CDC to decide the strategic guidelines for the project in compliance with the guidelines set forth by health authorities in the healthcare policy and the 2012 -2022 Master Plan.
3. Multiple working meetings with members of the EPI Technical Committee to decide the areas of intervention, objectives to be set, and strategies and activities to be developed within the framework of this project. This committee, comprised of senior technical personnel from the EPI National Directorate, PAHO/WHO consultants, UNICEF personnel, CDC consultants and members of the Brazilian Cooperation, took as their basis for these varied choices, the national healthcare policy, priorities of the new MPHP authorities, the Comprehensive Multi-year Plan for Immunization/EPI (cMYP/EPI) 2011-2015 and guidelines from actions in progress since the last IACH to strengthen the National Immunization Program.
4. The creation of a first draft that was presented to the members of the Inter-agency Coordination Committee/EPI on the occasion of a meeting held by the ICC on August 29, 2012, presided over by the Minister for Public Health and Population and assisted by the Director General. The meeting was attended by senior officials from MPHP, PAHO/WHO, UNICEF, CDC, Cuban Cooperation, Haitian Pediatric Society, Lions Club, Haitian Red Cross, SDSH/MSH, ACDI, Rotary Club, Japanese Cooperation, Brazilian Cooperation, and immunization experts from the National Program and other institutes throughout the country. It is noteworthy that on this occasion, consensus was made on the proposed areas of intervention, objectives set, and activities to be developed. However, it is also important to note the Minister's recommendations regarding:
    a. The integration of activities;
    b. Community human resources (multi-purpose healthcare workers) whose training

curriculum should not differ from the one currently used in the framework of the community health strengthening program;

c. The use of GAVI funds in addition to existing funds to finance other areas related to strengthening immunization services.

5. Meeting with the heads of the Planning and Evaluation Unit of the Ministry of Public Health and Population to collect data regarding financing for other programs whose services are to be integrated with those of EPI and also to understand the guidelines of the MPHP Master Plan under construction.
6. Creating the latest draft of the document from recommendations given in meetings held and interviews conducted.
7. Presentation of the latest draft to the Technical Committee, which will analyze and send a report to ICC for validating the document.
8. Signature of the document by the Health Minister and the Minster for Economic Affairs and Finance.

Finally, it is to be noted that this process did not require support from other sectors, organized groups or civil society, since the project is in continuation and complementarity with regards to the cMYP which witnessed high participation.

The creation of budgets and annual deadlines was aligned to the national healthcare plan and the financial cycle of the country.

1.2 Summary of the decision-making process

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

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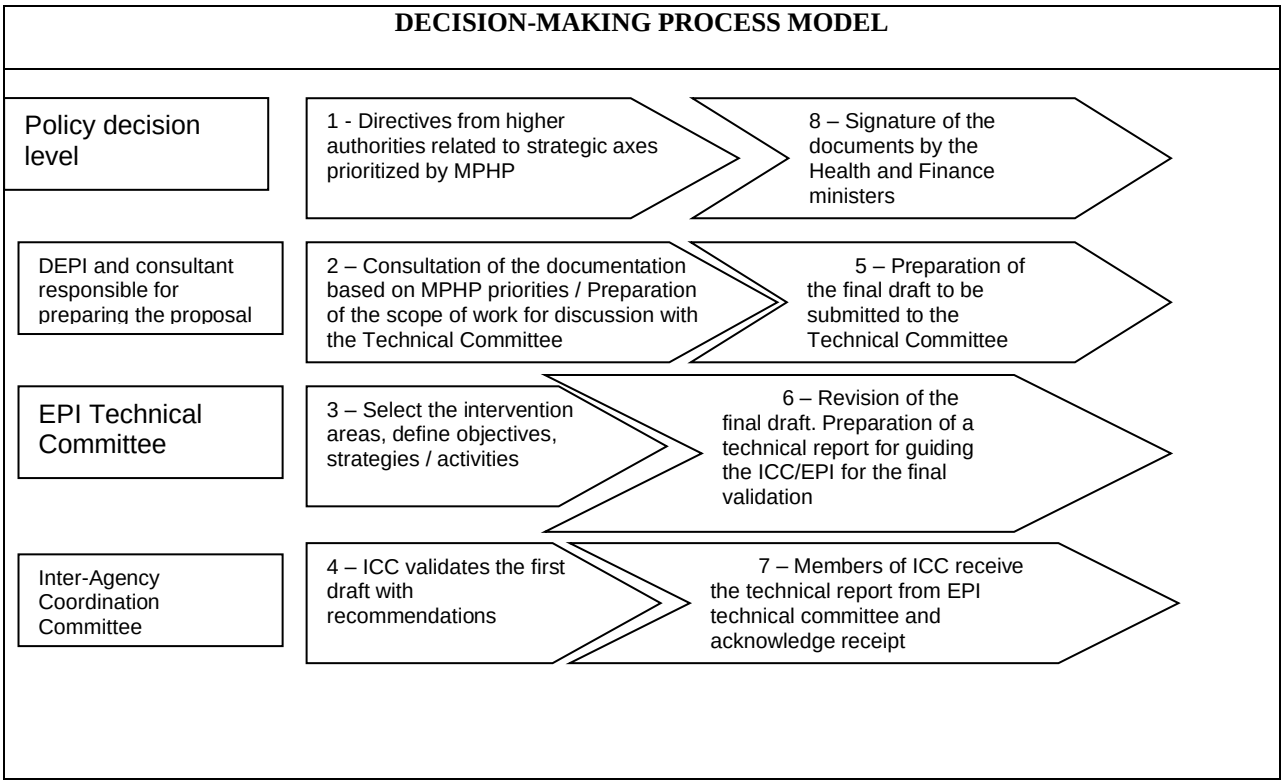
As we can see in the document update, considering the short time frame given for the realization of this work, the decision-making process did not go through all sub-committee committees and ad-hoc structures established during the creation of the document in 2007. On the contrary, the process directly used hierarchical structures of the MPHP and those of the Immunization Program coordination. The Inter-Agency Coordination Committee played its part in such conditions, whereas the Technical Committee acted as the Consulting Committee that was set up within the framework of the first proposal. The role of the Secretariat was played by PAHO/WHO. As a result, the document validation process was somewhat facilitated.
The process therefore went through the following eight (8) steps:

Step 1 (Policy): definition of priorities and strategic lines within the framework of the Proposal by the health authorities (Minister and Director General for Health);
Step 2 (Technical): Document review conducted by DEPI and the international consultant with priorities and lines defined by political authorities as the main guidelines;
Step 3 (Advisory): Support to the EPI Technical Committee (technical arm of the ICC/EPI) in the choice of areas of intervention, definition of objectives, and strategies/activities;
Step 4: Formulating the first draft for submission to ICC/EPI;
Step 5: Validation of the first draft by ICC with specific recommendations;
Step 6: Formulating the final draft for submission to the EPI Technical Committee;
Step 7: Revision of the final draft by the EPI Technical Committee and preparation of the technical report to streamline the decision for final validation of the document by ICC/EPI;
Step 8: Sending – with acknowledgment of receipt of the report and the draft – by ICC members and a signature on the Proposal by the Ministers for Health and Economic Affairs in case of no objection.



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

The Republic of Haiti covers one-third of the western part of Quiskeya island, which it shares with the Dominican Republic. It extends over a predominantly mountainous area of 27,750 km^2. The country is divided into ten (10) geographical and administrative departments. The Haitian Institute for Information Technology and Statistics (HIIS) estimates that in 2011 the population of Haiti was at 10,363,566 inhabitants. The age pyramid is that of a country that has barely begun the demographic transition.

The Haitian population is mainly rural (the overall rate of urbanization is calculated by HIIS as 46% with major disparities between departments). The density of population is 373 inhabitants per km^2. Around two-thirds of the population (61%) lives in scattered community habitats, which complicates care provision strategies for remote communities.

Child mortality in Haiti is the highest in the area of the Americas with 57/1,000 live births; major causes include: strong respiratory tract infections, diarrheal diseases, anemia and chronic malnutrition. Among the deaths due to common infections in infants less than 1 year-old, 31% are ARI, 26% are diarrheal,

and 13% are meningeal. Between the ages of 1 and 4 years, diarrheal diseases are in first position (37%), ARI are in second position (21%), and meningitis is in fifth position (9%).

It has been noted that from birth to 5 years, the main etiologies for death due to ARI and meningitis are Haemophilus Influenzae Type B and the pneumococcals; the main etiologies for death due to common diarrhea are rotavirus.

Maternal mortality remains amongst the highest in the world. It was calculated as 457/100,000 live births in the beginning of the 1990s; it then went up to 523/100,000 in 1994-1995 and reached 630/100,000 in 2005 (EMMUS II, III, IV Survey). Only 25% of births took place in a healthcare establishment. It is believed that about 1,800 women die due to maternity reasons every year, i.e. about 5 women per day. Moreover, only 18% of women of child-bearing age have access to modern contraceptive methods.

HIV/AIDS (2.2% prevalence calculated) and tuberculosis (high rate of detection) pose serious public health problems in Haiti.

On the other hand, routine **immunization coverage** in Haiti has revealed to be insufficient to ensure protection of babies from diseases that can be avoided through immunization; however, the country has conducted national campaigns over a long period of time, jointly with other American countries, for the eradication of polio, measles, and rubella.

In this context, the immunization program, like all other basic services, faces the problem of the population's limited access to healthcare services.

The administrative pyramid of the health system consists of 3 levels:

1. The strategic central level that ensures standardization, planning, monitoring, evaluation and control of healthcare interventions. The leadership and strategic lines are ensured by the highest authorities of MPHP, i.e. by the Minister and the Cabinet, aided by the Directorate General and central directorates.
2. The intermediate level where the ten health departments coordinate the service offer in the territory.
3. The operational level or service consists of 58 Community Health Units, the organizational base of healthcare decentralization, including healthcare institutions and community interventions.

The operational or service level forms the base of the health pyramid which includes:

a) The first service level which includes:
   - A first level represented by a little more than 600 First Grade Health Services (FIGHTS);
   - A second level represented by "Hôpitaux Communautaires de Référence" (community referral hospitals) (45), located at the level of the District head offices.

b) The second service level includes the ten departmental hospitals.
c) The third level includes 6 University hospitals.

The service sub-system includes about seven hundred twenty-two (722) healthcare service institutions. Amongst the latter, about 600 Health Centers with -and without- beds are organized into networks of around (45) community referral hospitals located at the level of head offices of 45 Community Health Units (CHU).

The service sub-system is very focused on remedial care basically provided in 1st and 2nd level service hospitals. Primary healthcare is mainly provided at the first level of the care service sub-system and is characterized by a deficiency in human and material resources, which constitutes an obstacle in ensuring the availability and quality of services offered.

The service sub-system also includes 51 care structures that offer specialized services or those at a level of complexity that does not allow for their categorization.

The Minimum Service Package (PMS–MSPP, January 2006) includes basic promotion, prevention and curative interventions that must be provided to the whole population at the first level of health structures

(FIGHTS and Community Referral Hospitals)

Health system segmentation

The health system is not uniformly organized at the territorial level. The segmentation makes coordination and control difficult. It includes various sub-sectors:

- **The profit-oriented sub-sector** which includes structures like clinics, polyclinics and private hospitals, mainly providing curative care to the section of population that can afford its cost.

- **The private, non-profit sub-sector** is made of organizations with various vocations. It includes religious missions providing healthcare in the course of their community services, or national or international NGOs whose prerogatives extend from support to a specific service delivery institution (for example, maternal, child, and HIV care) to conducting integrated development programs with actions on preventative and curative health.
  In the private, non-profit sub-sector, there are mixed private institutions (part of the personnel salaries are taken care of by the public treasury).
- **The public sub-sector** represented by public administration and service institutions.

The entire care services sub-system includes 908 service and care structures distributed as follows: 278 public institutions (30.62 %), 419 private institutions (46.14%), and 211 mixed institutions (23.24 %). *Source: Statistical Yearbook 2010, MPHP.*

Traditional Medicine (or leaf medicine) represents, in 70% of the cases, the first recourse of the population in the event of health problems. It is based on plants, and its knowledge is often passed down through families. It represents an instant remedy via self-medication or through the family circle. It refers to a person with a skill, such as midwives or traditional birth attendants (matrons).

2.1 b) National Health Strategy or Plan

In compliance with the National Health Policy, the Master Health Plan 2012-2021 proposes to operationalize the National Health Policy of 2012 through a health model organized around departmental health directorates.

This model restores the leadership of the Ministry for Public Health and integrates the community in the health pyramid. It recognizes and values traditional medicine while planning for modalities to strengthen and document it. In addition, this model emphasizes the interaction between various health systems, both private and public, in order to create a care pyramid integrating and coordinating various levels of institutions to guarantee a continuum of healthcare and services to the population.

At the administrative level, taking into consideration the potential resources and for reasons of rationality and efficiency, the District Health Unit replaces the Community Health Unit (CHU). Therefore,

- the District Health Unit becomes the operational level covering the municipalities and community sections and therefore the service provider institutions;
- the intermediate level corresponds to the Departmental Health Directorates;
- the central level strengthens its role in regulation, health development strategy creation, standards and procedures, and control and evaluation.

Supervision and control remain the two priority functions of the operational and intermediate levels.
Seen from this angle, the Master Health Plan searches for two types of results: i) organizational and operational; ii) related to the provision of services and healthcare.

Also, more specifically, for the period covered by this Master Plan -from 2012-2021- in agreement with the strategic lines of the National Healthcare Policy and the search to attain MDGs, the accent will be put on strengthening the health system and service provisions.

For each of these aspects sub-divided into areas, classes, categories and type of interventions

are defined as well as the results to attain them for every trimester of the Master Plan execution.

2.1 c) Health Systems Strengthening Policies and Strategies

Weak supervision capacities of the national health authority, multiplicity of lenders and vertical programs, and the absence of standardized protocols for health problems, and frequent interruptions in essential medical stock supplies, all contribute to the poor quality of healthcare at the institutional level.

Resources are often insufficient in logistics and an inadequate maintenance hinders their optimum utilization, especially in the case of the immunization program. Demand for immunization is high but the supply of immunization services faces several challenges such as bad cold chain management and the transportation of vaccines.

A large part of funding rests on the patient in a context where ¾ of the population survives with less than 2 US dollars per day (UNDP, 2005).

Projection of the GDP is to be increased over the years of the proposal (2013-2015), and the total health expenditure per inhabitant will remain at 40 US dollars.

The State provides close to one-third of the health expenditures. Overall, the budget allocated to the sector reaches 75 million US dollars for the 2009-2010 fiscal year of which around 80% goes towards payment of staff salaries.

The National Health Policy aims to strengthen development of activities in the community through health-related social participation, guide development of infrastructures in rural areas which are traditionally neglected, and develop and implement regulation for training and management of human resources, medicines, and other inputs.

The policy is organized around three axes: specific, global, and transversal.

- The specific axes integrate policies that target essential factors for production of services such as: **infrastructures, human resources and supply**.
- The global axes integrate policies that target necessary resources in order to mobilize the factors for the production of services such as: **funding and regulation of the health system**.

- The transversal axes integrate policies that target the entire gamut of resources of the system such as: **Information/monitoring, governance, social protection, integration, and intersectorality**.

Supply of healthcare services articulated for specific programs and verticals such as HIV or immunization, among others, favored the training of numerous community health workers involved in activities centered on one single program, thus breaking up the community approach.

Nowadays, dealing with these challenges, the politicians of the country show a clear willingness to commit themselves to the improvement of the situation. They show their explicit and precise intentions in the interest of Community Health and the choice of Primary Health Care (PHC) as a national strategy. It is therefore with this strategy that all national and international actors in the health sector, from all levels - strategic, financial, technical, operational (multilateral or bilateral cooperation, NGO, private sector), and those of the Ministry of Public Health and Population - have to align themselves.

Dealing with this situation, the following steps become imperative - developing a new healthcare model along with strengthening and extending first rate health services (FIGHTS) and implementing a real model of community health representing the basis for social welfare in health, using family and community healthcare as a strategy for starters, and relying on a strategy of Primary Health Care (PHC) and a Network of Integrated Health Services (RSSI).

Guidelines having a direct or indirect impact on EPI are mentioned in the fundamental strategic documents pertaining to the health sector. These documents include: National Heath Policy, National

Strategic Plan for Health Sector Reform, Minimum Package of Services (PMS), National Strategy Document for Growth and Reduction of Poverty, and the National Forum on Health Sector Realignment.

EPI priorities for the 2011-2015 fiscal years are as follows:

1. Strengthening Program governance in all aspects falling within the domain of the National Health Authority (NHA).
2. Developing routine EPI capacities on a sustainable basis to achieve and maintain quantitative and qualitative satisfactory vaccine coverage all across the territory, including the rural and peri-urban zones with difficult or marginal access, particularly those in the metropolitan area.
3. Achieving financial viability concerning the capacity to efficiently and reliably mobilize and utilize national and external resources which complement each other in order to achieve the current and future immunization objectives in terms of access, utilization, quality, security, and fairness.

2.2 Key Health Systems Constraints

→ Please describe the key health systems constraints at the national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunization, 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, marginalized, or otherwise disadvantaged populations (including gender-related barriers).

TWO PAGES MAXIMUM

2.2 Key health system constraints

As part of the development of this proposal, the main constraints of the health system will be divided into two parts. The following must be considered:

a) Systematic constraints
b) Specific constraints of the immunization program.

2.1.1 Systematic constraints and weaknesses

2.2.1.1 Limited access to services /service provisions

Only 61% of the population has access to health care. This is partly explained by the fact that the rural areas, where more than 40% of the population lives, are highly scattered and mostly located in remote areas. This situation is further aggravated by the inequitable distribution of health institutions and human and material resources.

Limiting the access also affects the quality of services provided in the difficult-to-access areas since, in general, only a few elements of MHP are delivered through advanced strategies and by staff who are still not well trained.

At the institutional level, the quality and regularity of service delivery are often affected by absenteeism of staff and shortages of inputs. The minimum services package is incompletely delivered at both the institutional and community levels.

On the other hand, the advanced strategies do not cover the entire territory. A large proportion of private institutions with non-profit goals have Community Healthcare Workers who deliver a package of preventive services through assembly stations or mobile clinics.

2.2.1.2. The challenge of governance and coordination

With the significant number of participants in healthcare, it is very difficult for the National Health Authority (NHA) to exercise leadership, coordination and adequate system management. The Public Health Code prepared in 2006 to resolve the problems of abusing the legal framework of the Ministry of Public Health and Population has not yet moved to the phase of discussion and validation.

The key functions of public healthcare are only tentatively carried out, and the National Information System (NIS) remains ineffective due to the heterogeneity of the parallel systems related to specific projects which are established without any coordination with NIS and MPHP.

Moreover, the quality and frequency of the supervision programs and activities also need to be

strengthened at all levels. Despite the availability of a national manual, supervision is still not used as a strategy to support and improve the performance of the staff.

2.2.1.3. Decentralization of services

There is no clear national policy on decentralization, and the health system remains centralized. The roles and responsibilities amongst the levels are poorly defined and often overlap. The Community Healthcare Units (CHU) are, thus far, the organizational approach for decentralizing the delivery of healthcare services. However, their implementation and development have been hampered each time due to the absence of a legal framework for institutionalizing them, and their mismatch with the administrative division of the territory as well as their lack of financial resources.
Few functional CHUs have however demonstrated the relevance and advantages of the approach.

2.2.1.4. Low funding and inefficiencies:

With 5.7% of GDP spent on healthcare in 2005-2006 and the expense of 32 USD per annum, per capita (MPHP, 2009), Haiti should have obtained better healthcare results.

However, since most of the funding comes from the patient's pocket, they or their relatives wait until their health is poor before asking for healthcare, or they do not ask for healthcare at all.

Moreover, the significance of international cooperation funds in funding health also poses serious threats in terms of dividing the system. For example, the expenses for HIV/AIDS are double the entire budget for public healthcare. Moreover, several programs in the areas of HIV/AIDS and others are designed in a completely vertical manner to show immediately visible results; this leads to an imbalance in services that are supported or not supported.

Finally, the state bears almost one third of the health expenditures. Overall, the budget allocated to the healthcare sector achieved $75M USD for the 2009-2010 fiscal year of which a major portion (approx. 80%) goes toward paying staff salaries.

2.2.1.5. Deficit in human resources (HR) and its low productivity:

With an average of 5.9 doctors or nurses for every 10,000 inhabitants and 6.5 health professionals for every 10,000 inhabitants, Haiti is far from the minimum standard provided by the WHO, which is set at 25 professionals for every 10,000. The human resources development is also subject to slow accreditation of several private schools for training healthcare professionals and the absence of strategic planning for human resource requirements. It also noted that there is the absence of a genuine policy for retaining staff in an environment having a strong attraction to the private sector and NGOs that provide opportunities with more attractive salaries.

Having human resources (HR) is not synonymous with providing quality healthcare services. There are multiple reasons for low productivity: low income, no career plans, difficult work and life conditions, as well as the absence of performance tracking mechanisms.

At the departmental Directorate level, the immunization programs are managed by a single coordinator who has further responsibilities in 1 or 2 other programs.

2.2.1.6 Impact of the earthquake of January 12, 2010

There have been devastating effects of calamities on the healthcare sector. In the three (3) most affected geographic departments (West, Southeast, and Nippes), 60% of the hospitals were severely damaged or completely destroyed. The offices and management resources of the Ministry of Health have been badly affected; the main building of the Ministry completely collapsed.

Movement of people (approximately 1.2 million people), has greatly increased the pressure on the healthcare system in departments not affected by the earthquake, making the calamity a national issue. Thousands of people were injured with more than 4,000 amputations performed.

While increasing the access to care, the arrival of several new participants posed additional challenges to the already weak coordination of the healthcare sector.

2.2.2. Specific problems related to the immunization program

2.2.2.1 Weaknesses in terms of planning and management

At all levels of the system, a weakness was observed in the ability of the program to operationalize the cMYP and monitor various indicators. This situation is more worrisome at the local level where the serving populations are not determined for all the institutions and where, the loss and dropout rates are not systematically calculated. On the other hand, given that the service providers are being trained in micro-planning these last two years, many institutions still operate without their annual micro plan.

2.2.2.2 Limited availability of data

EPI does not have a complete and reliable information system to analyze and make decisions. Also, the electronic systems and tools are not properly used. There is no efficient system for monitoring children who need to be immunized to reduce the dropout rates. The existence of multiple immunization records hinders monitoring the immunization status of the target groups.

2.2.2.3 Availability of immunization services

The daily availability of immunization services is not generalized at the institutional level. Missed opportunities are many and the parents, who are demobilized by waiting too long, give little importance to the immunization schedule and lose contact with the services. There are multiple underlying causes: absence or absenteeism of staff, shortage of vaccines, shortage of cold chain due to failure of refrigerators or non-refueling of propane gas. As for the advanced immunization strategies, they are inadequate, poorly-planned, and there are several areas where they are not even provided.

2.2.2.4 Problems related to the management of vaccine supplies and inputs / loss rate

The vaccine supplies are not managed or not documented well at the central level. In fact, even if the information on the arrivals, distributions and stock balances are communicated regularly by the central level, the peripheral warehouses which perform this management at the departmental level do not inform the central level.

2.2.2.5 Specific issues related to the monitoring of dropouts

The dropout rates between successive vaccines, specifically between DPT1 and DPT3 calculated from administrative coverage show large disparities between the departments. The CDC study of 2009 estimated this at 18.1% at the national level.

2.2.2.6 Monitoring of the program

Moreover, quality and frequency of the supervision programs and activities are also to be strengthened at all levels.

2.2.2.7 Problems related to communication/social mobilization

Communication and social mobilization is a weak link in EPI. An integrated communication/social mobilization plan for MPHP took too much time to be prepared and then to be implemented.

2.2.2.8 Epidemiological Surveillance

There is a network of 93 sentinel surveillance sites and a pool of epidemiologists, departmental laboratory technicians and surveillance officers who participate in the notification, investigation and response activities. While the Department of Laboratory Epidemiology and Research (DLER) organizes weekly coordination meetings in its activity room, the quality of supervision is still inadequate. In fact, the complete reporting is very low even at sentinel surveillance sites; case investigations and the responses do not always follow the notification or follow it fast enough.

2.3 Ongoing efforts for the Health System Strengthening (HSS)

→ Please describe the ***ongoing efforts for the Health System Strengthening (HSS)*** in the

country, supported by external and/or local resources, to overcome the major constraints of the health systems described above.

THREE PAGES MAXIMUM

2.3 Ongoing efforts for the Health System Strengthening (HSS)

To deal with these problems, the Ministry of Public Health and Population has started to implement a solid foundation for a genuine restructuring of the health system. For this purpose, it has taken into consideration all documentation produced during the Realignment Forum for the Reformation of the Health System conducted from 2006 to 2009. In fact, the situational analysis produced in this framework together with the results of the 2011 National Health Conference has served as basis for resuming actions on Health System Strengthening.

In this context, the Ministry has inducted suitable Commissions which, with the help of the international technical cooperation, had to develop strategic documents such as the National Healthcare Policy which should help in dealing with the problems identified.

On the other hand, the results of the National Health Conference held in April 2011 helped the top management of the MPHP to be informed of the priority issues faced by the intermediary health system and of alternative solutions to be proposed to them.

Based on the strategic guidelines of the National Healthcare Policy and the main principles on which it rests, and with reference to the results of the National Healthcare Conference and the findings of an external institutional audit of the Ministry of Health conducted in 2010, the Ministry has undertaken to develop a Master Healthcare Plan that will guide the interventions of the MPHP over the next 10 years in line with the strategic priorities mentioned in the National Healthcare Policy.

More specifically, to address the problems arising from the fragmentation of the healthcare system characterized by multiple donors who manage their funds based on their own priorities and procedures, the MPHP is currently establishing a Contractualization Unit for coordinating the use of external funds. This Unit will begin negotiating the funding mechanism with the health departments based on the results.

Along the same lines, with a view to strengthen the regulation of the health system currently operating under the aegis of laws that are inappropriate and outdated, the MPHP resumed the process of developing its Legal Framework that was interrupted with the publication of the “Code of Public Health”- the fruit of 2 years of discussion and reflection carried out with GAVI support and the result of the evaluation of the laws that governed the system during the 19th and 20th centuries.

On the other hand, the Ministry has released its new organizational framework that is consistent with the principle of integration advocated in the new policy. This framework provides a core structure in terms of the reduced number of Directorates in reinforcing the structure of the Departmental Directorates

A Directory of job descriptions for the posts available at the MPHP has just been launched which helped solve the problem posed by the presence of a large number of staff without functional titles. Finally, it is worth noting the decision taken by the MPHP to train 10,000 Polyvalent healthcare workers who will, in turn, contribute to the extension of basic healthcare services to the zones that are not easily accessible and to urban areas. To this end, the MPHP has held that there be a single curriculum for the training of this category of human resources who will have to ensure in delivering the Essential Health Care Package (EHCP)

All these measures aimed at strengthening the healthcare system will have a positive impact on the National Immunization Program. They will contribute, no doubt, to maximizing the ongoing efforts to strengthen the routine immunization program.

The Complete Multi-Year Plan (CMYP) 2011-2015 of the EPI rests on six major strategic axes, of which four are based on the broad guidelines laid down by the “Global Immunization Vision and Strategy” (GIVS) and two are derived from the specific needs of the program for more effective planning.

- Provide better protection to the people in the changing world
- Revitalize the Routine Immunization Program
- Strengthen the leadership of the MPHP

- Adopt new vaccines and new technologies
- Integrate vaccination, related health interventions and monitoring within the health systems.
- Vaccinate in an interdependent world

1- **Strengthening of the routine immunization program**

In order to increase the immunization coverage and be in compliance with the objectives of the 2011-2015 EPI multi-year plan, the MPHP, with the support of its partners, has decided to put an emphasis on strengthening the EPI while guaranteeing its viability as well as the quality of its services. This accelerated HSS process will be initiated during the period of August to December 2012 and then be developed in 2013 with the help of a detailed operational plan under the CMYP 2011-2105.

In this context, for the rest of the year 2012, the focus will be on:

- the structural strengthening of the Expanded Program of Immunization;
- the introduction of the Pentavalent vaccine next September;
- activities that might contribute to the elimination of neonatal tetanus, increased immunization coverage and the strengthening of epidemiological surveillance.

Interventions that aim to improve the sustainability and performance of the routine immunization program shall be considered from 2013.
All these activities will be conducted continuously while building on the lessons learned and the best practices drawn from past experiences.
In this context, the technical and financial support from partners will be coordinated by the Ministry of Public Health and Population. The essential elements of the strengthening program include:

2- Broadening the spectrum of diseases and target populations.

As we know, with GAVI support, the program will introduce the Pentavalent vaccine nationwide at the end of 2012 and the Pneumococcal and Rotavirus vaccines in 2013. This increases the capacity of the healthcare system in lowering the rates of infant and childhood morbidity and mortality. With preventive measures against diseases ranked among leading causes of morbidity and mortality among children under 1 year-old and children under 5 years-old, there is no doubt that if the country does not meet the MDGs by 2015 it will at least be very close to it.

3- Reviving of the immunization program into the advanced strategy

In this framework, the 10,000 polyvalent healthcare workers who are being trained by the MPHP will serve as important resources for the realization of the advanced strategies. Updating of the departmental and communal health cards and the definition of territories and populations serviced by each health institution will be undertaken. This will be supplemented by the implementation of a regular monitoring system for the extension of integrated immunization services.

At the same time, the good results obtained by the implementation of the RED (Reach Every District) approach in 36 communes in 2011 has encouraged the program coordinators to extend this experience to 40 additional communes in 2012-2013.

4- Improving the cold chain capacity

Increase the capacity of the cold chain at all levels to meet the storage requirements resulting from the introduction of new vaccines. This current approach also focuses on the appropriate development of peripheral depots which must not only help commission the cold chain units but also help in storing all EPI inputs.

5- Improving the management practices with regard to the cold chain, vaccines and other inputs

In this context, training sessions in vaccine management and cold chain management are planned and have the purpose of training the cold chain technicians at the central and departmental levels. It is also planned to recruit a cold chain consultant at PAHO/WHO to supervise the cold chain staff and help them in performing the functions assigned to them.

6- Strengthening communications and social mobilization activities

A national communication plan will be operationalized at the departmental and local levels to maximize demand and improve service delivery, particularly in the remote areas.

7- Strengthening of Epidemiological Surveillance

The surveillance system on vaccine preventable diseases while being an integral part of the national epidemiological surveillance system, must have a certain degree of autonomy and deserve special attention to the extent that the country is about to be certified as being free from measles and rubella viruses and to the extent that it must continue to work to maintain polio eradication in the country. It should also be emphasized that the introduction of the new vaccines such as Pentavalent, Pneumococcal, and Rotavirus must be accompanied by a monitoring system that works adequately to ensure proper monitoring of the effectiveness of these new vaccines.

8- Revival of the planning, support and monitoring activities

In this context, tools and guides to be used for the systematization of the micro-planning are being finalized. Parameters for monitoring are also being revised while resuming the bi-annual sessions on monitoring at the central level and the quarterly sessions for monitoring at the departmental level.

In addition, tools for the management and monitoring of EPI activities are being developed

9- Strengthening of the management and consulting bodies

The National EPI Directorate, the EPI Departmental Units, the Inter Agency Coordination Committee and the EPI Technical Committee are currently being strengthened.

In general, through this plan, the DEPI and its technical and financial partners have to commit themselves to coordinating their actions better, learn lessons from the past and endeavour to achieve the desired results.

The MPHP has assessed and finalized the diagnostic and the update of the cold chain inventory which was carried out in 2005 for adapting it to the current requirements of the program and provide a functional cold chain throughout the year in at least 80% of the institutions participating in the EPI.

An immunization campaign for the elimination of measles and rubella and for keeping the country free of polio was conducted in early 2012 with very good results. The lessons learned from this intervention will help make appropriate decisions for strengthening the routine EPI.

For an efficient implementation of the strengthening program, additional staff has been planned to be recruited as follows:

	Support for	
Level	EPI	EPI Monitoring
Central	4 Haitian professionals	2 Haitian professionals
	4 international consultants (central and departmental support) 3 international consultants (Logistics, Information systems, and Communication)	
Departmental	11 Haitian professionals	11 Haitian professionals
	11 Haitian professionals (from the West, from Nippes, Southeast, Northeast and from the Northwest)	

3. Healthcare System Strengthening (HSS) 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 immunization, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.

TWO PAGES MAXIMUM

The purpose of the GAVI-HSS support is to contribute to increasing the effective coverage of immunizations by strengthening the program management at the national and departmental level and to increase the universal access to integrated and quality immunization services.

The strategy is mainly to expand the immunization services integrated with basic quality health care, using a new structure for institutional and community services. Strengthening the immunization services will contribute in strengthening other services and the health system as a whole. The mother and child health services, management, information, health education and staff training will particularly benefit from this.

3.1 Objectives:
The objectives of the Health System Strengthening to be carried out within the framework of this proposal are:

1. Improve the capability of programming and monitoring the Program and immunization services at the three levels of the system.
2. Strengthening the Health Information System.
3. Strengthening the access and organization of immunization services.

First, the project will facilitate the prevention activities contained in the Essential Services Package at the family and community level with top priority to the mother and child.

In addition, strengthening the service network will provide an institutional platform to introduce new vaccines (Pentavalent, Rotavirus, and Pneumococcal). Strengthening the regular program will mainly contribute in keeping the country free from polio, measles and rubella and also in eliminating neonatal and maternal tetanus.

In terms of results, the project will also contribute to a reduction in morbidity and infant and maternal mortality.

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

SIX PAGES MAXIMUM

3.2 *a)* Narrative description of programmatic activities

This proposal was designed to bridge the gaps identified in the 2011-2015 Comprehensive Multi-Year Plan of the Expanded Program for Immunization in terms of key interventions or topics not covered by secured funding.

Prioritization of key interventions, establishing objectives and the determination of the Health System Strengthening Plan (HSSP) were made on the basis of the new health policy and the master plan from MPHP. On the other hand, the 2011-2015 Comprehensive Multi-Year Plan /EPI and the program evaluation reports have also helped to guide this approach.

The **Purpose** of this proposal is perfectly in line with the National Healthcare Policy, Strategic Plan for the Healthcare Sector and with cMYP for 2011-2015. This purpose, on one hand, aims to increase effective immunization coverage by strengthening the program management at the national,

departmental and local levels and, on the other hand, to increase the universal access to integrated and quality immunization services.

It is understood that, through the GAVI-HSS proposal, MPHP will optimize the immunization by completely or partially involving the elements of the Essential Healthcare Services Package (EHSP). This presumes a first level of operation with the required Polyvalent staff, organized services and the availability of the necessary inputs. The purpose also announces the interventions that will be operationalized to provide a solution to the problem of inequitable access to immunization services. It finally signifies the emphasis which will be placed on the managerial and organizational level and thus strengthening the program at all levels, which is essential to achieve sustainable results.

This team conducts the local census to obtain key denominators for planning the basic programs. Once the data about the population by age is known, it will not only establish routine immunizations with regular monitoring and home visits by PCHW but also catch-up, if necessary.

The Objectives focus on the aspects that are considered most essential to achieve the goal.

Objective 1: Improve the ability for planning and monitoring the Program and immunization services at the three levels of the system.
This objective is defined based on the findings in the program reports and analysis and highlighting the weaknesses of EPI in its ability to operationalize the cMYP at the three levels of the system and monitoring the various indicators. However, this situation becoming more alarming at the local level; the priority will be given to the supervision of service staff in developing community and institutional micro-plans in using immunization coverage monitoring tools, loss rates and dropout rates.

Objective 2: Health Information Systems Strengthening
In this area, based on the problems identified, the actions planned relate to a) the revision of EPI information sub-system tools and epidemiological surveillance sub-system for diseases avoidable by immunization (activities already completed); b) adapting these tools to new requirements of the program information sub-system; c) printing and propagating these tools; d) popularizing these tools and training managers and service providers on their use.

Objective 3: Strengthening the access and organization of immunization services
Many immunization services do not meet the minimum structural and functional requirements to ensure quality immunization services (see MSP and MPHP). Considering this situation, the objective emphasized the need to strengthen the service organization function based on both structural and operational functions. In other words, we should tackle the problem from multiple angles at the level of services: physical, dimensional, equipment and organizational. The same objective also covers access to services which is very limited, especially for the people living in the difficult-to-access and isolated areas, disadvantaged people and in marginally urban areas.
This part of the objective presumes the measures, strategies or approaches which should be adopted so that the children, mothers and other members of the family, irrespective of their socio-economic status, religion, level of education, residence, can use or benefit without significant social or economic cost of immunization services associated with other key elements of the basic health services package.

Activities: They are related to the established objectives. They generally focus on various interventions or actions required to achieve the objectives.

1.1. Revision, adaptation, production and distribution of healthcare cards

These are very important tools for local and integrated planning, which will help to locate service institutions, who provide immunizations, fixed immunization stations, draw their area of responsibility, identify obstacles that may affect access to immunization services, locations not accessible by the services and locate sentinel epidemiological surveillance sites. The healthcare cards are active. They can be modified if and when the above situations change.
They are an important strategic tool for monitoring the extension of services and their geographical coverage. The blank cards with minimum information are acquired either from the Haitian Institute of Statistics and Information or from other specialized agencies of the place. Once available, they are updated during the micro-planning sessions. It may also require hiring a firm to collect the data

necessary for creating a database to update the cards.

1.2. Revision and preparation of integrated micro-planning tools for adapting to the conditions and local requirements and capabilities of staff and service

There are micro-planning tools for routine and intensive immunization activities. However, as they are being tested, they should be revised, updated, if necessary, and adapted to the integration requirements of other services.

Micro-planning tools include: a micro-planning guide which could be used as a reference by the supervisors and service providers and also must ensure the standardization of plans.

1.3. Development of an EPI action plan from the local level to higher levels

This will direct all the efforts towards meeting the real needs of the population and ensuring the availability of means to be implemented to extend and strengthen coverage and access.

Based on experiences from previous years, the national immunization program will set-up and carry out a bottom-up planning process. The process will include the following steps:

a) A local micro-planning phase, which could be either institutional or municipal depending upon the case. To achieve this, each institution should provide the following information: a list of communities that are served, the location of immunization stations of the previous intensive immunization activities, communities served by assembly stations and now by regular program and number of PCHW. All this data must be used to update the municipal healthcare card and enhance the micro-planning process itself.
b) A departmental planning phase which consists of summarizing local micro plans to which the activities to be developed by the departmental directorates to supervise and assist the institutions must be added.
c) A departmental plans summary phase to which the interventions that should lead the central level by supporting the execution of departmental plans should be added.

These activities mainly consist of conducting workshops involving 1 or 2 local officials per institution and representatives from the communities served- local elected officials. At the departmental level, the program in-charge participates in summarizing the municipal and institutional micro-plans: departmental coordinators, cold chain technicians, administrative officials and departmental epidemiologists. As mentioned above, the guidelines, data processing tools for programming and budgeting should be prepared and provided before the sessions.

1.4. Revision and development of integrated supervision tools

The supervision system is one of the most important components of the program since it is a local strategy which helps not only in identifying the structural and operational problems which sometimes have a negative effect on the performance of the program but also make it on-site (if possible) and jointly with the relevant appropriate solutions. It also monitors the execution of plans at all levels of the health system. The issue of the irregularity of visits, a lack of use of reports, and the absence of retroactive information will be addressed in this project. For this purpose, it is necessary to revise the requirements, complete and propagate the supervision tools, and train the supervisors for their use. It is also essential to provide the necessary funds to the central and departmental levels for funding the field visits. It should be noted that the central level teams will conduct integrated supervision activities, every 3 months, of the health departments for 10 days while the departmental Directorate teams associated with those of CHU will conduct supervisory visits of health institutions every 2 months. The institutional in-charges will supervise the advanced strategies once a week. It should be noted that the appointment of additional staff in the national EPI directorate and departmental EPI units will contribute to strengthening their supervisory capabilities.

1.5. Training persons involved in the integrated supervision at the EPI will ensure that the supervisory activity and the use of developed tools are carried out well and the results are achieved.

Training the staff in the use of supervisory tools and the application of supervisory standards and procedures is required since the practice is not completely institutionalized at the program level. The training is especially essential for the supervisor to adopt an appropriate leadership style for the

execution of tasks.

1.6 Execution of quarterly integrated supervision tasks from the central level to the departmental level

The central level supervisory teams composed of DEPI and Technical Committee executives (PAHO/WHO-UNICEF-CDC) execute 4 major annual tasks of at least 10 days each in the 10 departments. During these missions, these teams supervise the management of all program components with the Departmental Directorate, identify problems and bottlenecks and make recommendations. They also have the opportunity to visit the CHU coordination offices and health institutions.

1.7 Execution of bi-monthly integrated supervision from the departmental level and CHU to health institutions

The departmental level supervisory teams composed of EPI and CHCD executives, execute 6 major annual tasks of at least 15 days each in the municipalities and health institutions. During these missions, these teams supervise the management of all program components with the CHU or communal coordinates, identifies problems and bottlenecks, make recommendations. They also have the opportunity to visit the communities (certain advanced strategy stations).

1.8 Strengthening the EPI Information system

Strengthening the EPI information system focuses on the revision and adaptation of EPI information system tools which will involve, specifically: a) the design and adoption of a new national immunization card which will be used not only by a child under 1 year-old but also when he/she becomes an adult and will receive all other vaccines such as: dT, HPV, anti-cholera, etc. This card will be specific to the program and the child's passport will serve as a backup which will be updated regularly with the doses received (in case of children). This card will be given to the parent or the immunized adult, while a copy will be kept in the institution and put in a folder in the compartment for the month in which the next dose should be administered. This will identify the children or persons who should receive their subsequent doses during the month. A mobile telephone provided to each institution with fixed usage terms will be used to call the people who have failed to turn up or latecomers. This will be facilitated by writing the 2 telephone numbers (the mother or the guardian and the emergency contact number in case the parents are not available) on the card given to the parents and on the copy thereof.

1.9 Production of EPI Information sub-system tools

The EPI management and information sub-system tools were revised by the members of the EPI Technical Committee assisted by the PAHO/WHO consultants. These tools are classified by domain and for each of them are defined the objectives, method of completion or use, usage level and transmission or distribution routes. All of them are compiled in a book that will be more useful to the service provider or the manager.
These tools will be multiplied depending on the requirements at each level.

1.10 The training

Will provide quality data essential for the correct analysis and interpretation of results.

1.11 Revision of data management tool

A computerized system will be adopted for managing inputs and will be used by the central and departmental levels. It should help in better managing the vaccines and immunization materials at all levels. On the other hand, the statistical database that is currently being used will be revised and possibly replaced by another which can be more easily used by the DEPI and the departmental-level executives. These tools will make it easier for the collection and transmission of information and also for the analysis and interpretation of data. In order to familiarize the staff in the use of these tools, workshops will be organized with the technical support from experts.

1.12 Allocation of the necessary computer equipment for data management at the central and departmental levels

In order to facilitate the processes of data collection, processing, analysis and their transmission at

higher levels, the statistics and IT departments of DEPI and departmental EPI Units will be given IT tools (computers, modems, etc.) with sufficient capacity to store data and the necessary software to execute the work. At this level, the project will provide Internet access.

1.13. Strengthen the monitoring of immunized children using new technologies

The mobile (cellular) telephone has become a popular tool used by all social classes for communication, be it city dwellers, urban poor or people from remote rural areas. This network situation that is widespread almost across the entire country by telephone companies is an opportunity to run EPI to provide customized monitoring of the target program. For this purpose, as mentioned above, the mobile numbers of the child's mother and the emergency contact number written on the immunization card and on the copy kept at the institution will be used to remind that the child has not come to the Centre to receive the vaccine. The planned activity is to acquire a mobile telephone for each health institution.
For this purpose, a call for tenders will be launched to recruit a firm according to the conditions that are most favorable for the system.

1.14. Improve the structural organization and operation of immunization services

This activity includes organizing and certifying the immunization rooms so that the services can be delivered in a functional environment, equipped as per the MSP and favorable to provide quality service and security for the child population and adequate program management, i.e. a clean, well-defined, well-lit, organized, and easily accessible location.

1.15 Support the movements of Polyvalent Health Workers

In other words, it will bear the operational costs planned as a part of the execution of advanced strategies. The following costs will be borne by the project: transport from the healthcare center (round trip) to localities or districts or to return back to the assembly stations, break or lunch, depending upon the distance. On average, these expenses will be for the Health Workers (5 per health institution) which will depend upon those service institutions that do not have them. It should be noted that updating or preparing the healthcare card will identify underprivileged areas, for which we should decide the strategy to be used to provide these services.

1.16 **Equip mobile immunization teams with the means and tools required for their position**

The Polyvalent Health Workers will receive a uniform, boots and a bag as incentives so that they can be identified. This will help to motivate them by giving them a certain prestige in their community.

Awareness campaigns, active monitoring of the target population for reducing dropout rates and immunization in difficult-to-access areas will also rely on the organizations and civil society.

3.2 b) Logframe

Proposal level	**Brief description of goals, service delivery areas and activities**	**Implementation responsibility: identification of the main execution entity or the execution sub-entity responsible for the implementation**	**Indicator(s)** *The candidates need not specify the "result" indicators at the "activity" level. Please read the data from the instruction sheet for more information*
Goals	Contribute to the increase in the effective immunization coverage by strengthening the program management at	DEPI/MPHP Health Departments	Percentage of surviving children aged less than 1 year who received 3 doses of Pentavalent Percentage of municipalities having reached a Pentavalent coverage greater

	national and departmental levels and the increase of universal access to integrated immunization services and quality		than or equal to 80%
Objective 1	Improve the ability for planning and monitoring the program and immunization services at the three levels of the system.	DEPI Officials Departmental Directorates Officials of the service provider institutions	Number of departments having an annual operational plan for EPI Number of institutions having an EPI micro-plan Existence of an annual operational plan at the central level Existence and use of monitoring tools at the 3 levels of the system.
DPS	**Effective delivery of healthcare services**		
1.1	Design, production and distribution of community maps	EPI National Directorate	Number of communities with maps
1.2	Revision and development of integrated micro-planning tools	EPI Technical Committee	Number and percentage of health institutions using micro-planning tools in sufficient quantity
1.3	Development of an institutional micro-plan integrating the advanced strategy together with the extension of services	Departmental directorates with central level support	Number and percentage of health institutions having a micro-plan integrating the advanced strategy as an approach to extend the routine activities
1.4	Revision and development of integrated supervision tools	EPI Technical Committee	Existence of revised supervision tools in sufficient quantity
1.5	Training of staff involved in the integrated supervision of EPI	Central EPI Directorate / Departmental directorates	Number and percentage of training sessions for integrated supervision held by the department Number and percentage of institutions with at least 1 staff member trained in integrated supervision
1.6	Quarterly supervision from central level to the departments	Central EPI Directorate/ EPI Technical Committee	Number and percentage of supervision activities carried out by the central level to the departments
1.7	Bi-monthly supervision of the department to the institutions and CHU	Departmental Directorates	Number and percentage of supervision activities carried out by the departmental level and the CHU to the healthcare institutions
Objective 2	Strengthening the Health Information System		EPI information system tools available at all the levels and used properly. Loss rate between Penta 1 and Penta 3.
	Information system		
2.1	Design and production of the integrated national immunization card	National Directorate of EPI/UPE/MPHP	National immunization card produced and available in sufficient quantity
2.2	Production of EPI information system tools	EPI National Directorate	EPI information system tools revised and available in sufficient quantity
2.3	Training the service providers in the use of	National Directorate of EPI	Number and percentage of institutions with one staff member trained in the use

	tools	/ Departmental Health Directorate	of tools
2.4	Revision of the existing data management tool and design or adaptation of a tool to EPI requirements	External expertise.	Availability of a powerful and easy-to-use software for managing the inputs Availability of a powerful and easy-to-use software for managing service statistics.
2.5	Allocation of computer equipment at the central and departmental level for data management.	EPI National Directorate	Departments equipped with computer equipment for data management
2.6	Strengthen the capabilities for monitoring the vaccinated child by using new technologies (mobile telephone)	EPI National Directorate	Number of institutions equipped with the system for retrieving data on vaccinated children using a mobile telephone.
Objective 3	Strengthening the access and organization of immunization services		Number of districts who achieved or exceeded the vaccine coverage targets fixed for the year Number and percentage of institutions implementing the advanced strategy.
3.1	Improve the structural and functional organization of immunization services	National Directorate of EPI/ Departmental Directorate/ support from consultants	Number and percentage of immunization services responding to the organizational and equipment standards provided in the MPS
3.2	Support the Polyvalent Community Health Workers teams responsible for the extension of routine immunization services	National Directorate of EPI / Departmental Health Directorate/UCS	Number and percentage of days / field / Polyvalent health workers used
3.3	Provide the immunization teams with required means and tools for their field trips	National Directorate of EPI / Departmental Health Directorate/UCS	Number of polyvalent health workers who received uniforms, boots, bags and hats.

3.2 c) Evidence base and/or lessons learned

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

Several documents: strategic plans, assessment reports of operational research results, and others were used as sources of information to draw up this proposition. Included in these documents are two examples of lessons learned with respect to the proposed activities.

1) The final report of the Intensive Programs for Child Health (IPCH): immunization of almost 3 million children below 10 years of age. The Intensive Programs for Child Health (AISE) was a success. In fact, the highest estimates for coverage were surpassed. As the basis for this success, the supervision and guidance provided to the regional departments in terms of planning, organization and coordination of the IPCH and health institutions for micro-planning and implementation of activities must be highlighted. Throughout the implementation of the activities and even a month afterwards, each of the departments received a team of supervisors / guides

consisting of international consultants, national MPHP officials and UNICEF personnel, who stayed on the site for over a month, providing local support to regional departments as well as service provider institutes. It should be mentioned that this approach was initiated between 1987 and 1994 during intensive immunization campaigns which resulted in the eradication of polio and measles.
Encouraged by the benefits of this experience, the National Authority for the Expanded Program for Immunization (EPI) laid emphasis on training-based supervision resulting from local management at the supervisory level. Therefore, the supervision tools were revised and adapted, while a training program for central and departmental level supervisors is planned for the utilization of these tools. In addition, measures were taken to institutionalize supervision as a means of improving the performance of the program.

2) Report on the implementation of RED strategy: As we know, the "Reach Every District" (RED) approach was recommended by institutes that promote the Global Immunization Vision and Strategies (GIVS) as the selected strategy to satisfy the immunization coverage requirements of the Millennium Development Goals.
In 2011, the national immunization program implemented the RED approach (to reach every in Haiti) in 36 municipalities with low immunization coverage. This contributed largely to the improvement in the performance. As an example, Diphtheria-Tetanus-Pertussis, 3rd dose (DTP3) rose from 61% in 2010 to 85.4% in 2011. The following reasons, among others, are listed out to account for these results:
   - Systematization of micro-planning,
   - Improvement in management,
   - Revitalization of supervision and advanced immunization strategies,
   - and strengthening of alliances with communities.

In addition, the implementation of certain support activities should also be emphasized:

- The regularity of weekly meetings between MPHP, OPS and UNICEF: during these meetings, immunization coverage and actions to be taken in all or some regions or municipalities were discussed, among other matters. Poor performance as compared to goals to be achieved for the period. After this follow-up meeting, conclusions and recommendations are communicated to the regions. (Feedback to the DDS and proposal of actions to be taken). In cases where the coverage achieved was higher than the planned coverage, supervision missions were organized to verify the quality of the data.
- The most frequent supervision missions from the central to departmental level and the departmental to operational level
- Organization of evaluation meetings at the national level with all the regions (the data and status will be discussed later).

3.3 Main Beneficiaries

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

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Activities related to Objective 1

Improve the ability for planning and monitoring the program and immunization services at the three levels of the system.

The ability to improve in terms of micro-planning, taking into account the possibility this creates while updating municipal and local health maps, to identify the areas that are not served which are usually difficult to access, contributes to guarantee populations of the rural zones access to basic health services, including immunization. Once these areas that are not served or those that are difficult to access are identified, it is up to the healthcare officials to choose the service strategy that would best respond to their geographical, cultural and socio-economic characteristics.
In the micro-plan are included all the resources necessary for the application of selected strategies and the provision of an equitable package of services. At the same time the supervision must guarantee the quality of services which should be provided in an equitable manner on this base.

Activities related to Objective 2

Health Information Systems Strengthening
Activities related to the strengthening of the EPI information system and the epidemiological monitoring of diseases preventable through immunization should permit the availability of information necessary for taking opportune decisions for the successful development of the program and the health of children and mothers.

In this context, the use of modern technology should be mentioned, namely the use of mobile phones for tracking drop-outs and stragglers -wherever they may be- and irrespective of their social status or gender. One can conclude that the information sub-system of the EPI contributes to reducing social inequalities in terms of healthcare.

Activities related to Objective 3

Strengthen the access and organization of immunization services

The activities related to these objectives are in perfect accordance with the principals of equity and quality, two of the principles in which the national health policy of the MPHP is rooted.
First of all, it should be considered that the strengthening of access aims to provide services to populations located far away from the places where they could benefit from immunization or that are completely deprived of this facility or that only have the possibility occasionally to benefit from the immunization campaigns. The decision to use Polyvalent Community Agents for advanced strategies is a further guarantee of quality assurance since these healthcare workers are trained not only in immunization but also to offer best quality services, with the complexity taken into consideration.
In brief, one can confidently state that the activities related to the three objectives aim to remove the barriers that hinder the equitable dispensation of services. These activities will be able to reduce inequalities related to gender, geographical location, and the content (quality) of essential health service packages.

Health service workers and, in particular, those working with immunization services should also gain from the project due to the reorganization of services and infrastructure, the use of new tools and methods of working, training, as well as better transport.

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 Monitoring and Evaluation (M&E) Plan and Performance Framework for the proposal. (Attachments 3 and 4)

Monitoring and evaluation, including research activities, will be an integral part of the implementation process. It aims to appreciate, on one hand, the effectiveness and efficiency of the interventions through indicators for inputs, operational results and effects and the strengthening of the national health system on the other. It should enable the stakeholders, at various levels of the system, to monitor and continuously improve their performance in the implementation of the Master Health Plan.

At the end of each year, the DEPI organizes a review meeting with the Departmental Directorates which is primarily used to evaluate the performance of the program for the current year. At the end of this fiscal year, and according to the objectives of the cMYP, an operational plan is established for the following year. The operational plans are subject to a mid-term assessment which is used to modify strategies and activities to achieve the objectives.

4.2 a) M&E arrangements

The indicator related to the head in **"Percentage of surviving children less than one year of age who received 3 doses of Pentavalent"** is calculated for every institution and jotted down in the institutional monthly report used at the national level. This report is generated from data collected at the institutional and community levels from their daily and monthly record books (used in the EPI information system at the national level).
These two documents, namely the monthly report and monthly compilation ledger, are transferred to the Municipal Health Unit (where it is functional) and the Departmental Health Directorate after updating the performance chart on immunization coverage. The CHU and/or Departmental level compare the data provided by the monthly report with that of the monthly compilation ledger before entering them into the database for analysis. Then the data are sent to the central level as a soft copy where they are subjected to further analysis. The monitoring of this indicator is done at all levels:

- Institutional level: through the monitoring chart on immunization coverage. At this level, this indicator can be monitored monthly thus giving the local officials time to reorient their strategies in the event that their performance curve runs below the monthly target.
- Departmental level: during quarterly monitoring meetings of the annual departmental operational plans, attended by representatives of all private and public institutions which provide services to the department of health and partner organizations working in the health sector at the department level. At this level, the department officials can recommend remedial measures to non-performing municipalities or institutions. For certain municipalities with very low coverage, additional intensive activities may be recommended.
- Central level: during annual national monitoring meetings of the operational plan attended by officials of the 10 regions, members of the CCIA and the Technical Committee of the EPI. At this level, the department officials can recommend remedial measures to non-performing municipalities or regions. For certain municipalities with very low coverage, additional intensive activities may be recommended.

The indicator related to the 1st objective "Percentage of municipalities with an EPI micro-plan that has been implemented"
The sources of this indicator are related to micro-planning sessions and quarterly reports presented during monitoring meetings of departmental operational plans and in national bi-annual meetings.
There are also copies of micro-planning reports and quarterly monitoring reports of departmental plans.
As in the case of the indicator related to the goal, supervisions also allow the collection of this information and help those institutions without a micro-plan.

The indicator related to the 2nd objective "Rate of loss between the 1st and 3rd dose of Pentavalent"
The sources of this indicator are the monthly institutional reports and daily, then monthly, record books. In the case of a high rate of loss, catch-up activities may be recommended.
For the transmission of this information, refer to the objective related to the goal.

The indicator related to the 3rd objective "Percentage of communes in which the advanced strategies are implemented"
The sources of this indicator are the reports of the micro-planning sessions, monthly institutional reports, daily and monthly record books, reports of quarterly monitoring, meetings of departmental plans, etc.
For the transmission of this information through monthly reports, refer to the objective related to the goal.

4.2 b) Strengthening of monitoring/evaluation/improvement systems included in the information system

The tools of the Health Information System have been subjected to a systematic revision which resulted in their adaptation to the new information requirements of the program. With this revision, the program has created a sub-system of information of the EPI.
With respect to the actual sub-system of monitoring/evaluation, the strengthening measures will cover the following aspects:

- Increase in the capacity of active monitoring of the target which includes:
    - Creation of a national immunization card which will be used by the person as child and later, as adult. This card will be given to the parents while a paper copy will be retained at the institution. The 2 cards will contain the address and two telephone numbers: that of the mother or guardian and that of the most reachable family member.
    - Introduction at the institutional level of a 12-compartment sorter in which each card will be classified according to the month in which the child is due to receive the next dose.
    - Availability of portable cell phones in each institution which would allow for the sending of reminders to drop-outs and stragglers that they should come to the center to receive their dose of vaccine (reminder of missed appointments).
- In addition, the program will multiply the performance charts of immunization coverage which needs to be provided to all institutions. Filled regularly and displayed, these charts will allow the staff to monitor the progress of coverage.
- Finally, the program will have 2 new software programs: one for the management of inputs and the other for the management of services-related statistics. The software tools will offer the advantage of being viewable by all officials of the DEPI and the regional departments. The possibility of including the central office with the departments in the network will be considered.

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. Attachment 5.

Attachment 5 presents the contents of the detailed work plan and budget. The resource requirements for the years 2013, 2014, 2015 were established based on the complete multi-year plan presented in the following table

Table 10: Summary of costs and resource requirements – consolidated version

	Expense	**Future Resource Requirements**					
Components of the multi-year plan	**2006**	**2011**	**2012**	**2013**	**2014**	**2015**	**Total 2011-2015**
	US$	**US$**	**US$**	**US$**	**US$**	**US$**	**US$**
Vaccines and Logistics	$1,224,539	$2,239,851	$8,792,768	$15,694,691	$15,139,401	$16,548,823	$58,415,534
Services provided	$3,636,876	$3,766,918	$3,869,767	$3,975,230	$4,055,140	$4,432,036	$20,099,091
Advocacy and communication	$847	$102,000	$104,040	$159,181	$162,365	$165,612	$693,198
Monitoring and Epidemiological Surveillance	$14,500	$377,910	$385,468	$393,178	$401,041	$409,062	$1,966,659
Program Management	$109,267	$2,115,480	$2,157,790	$2,200,945	$2,244,964	$2,289,864	$11,009,043
Additional Immunization Activities		$6,779,424	$706,117	$7,611,142	$6,298,211	$4,538,096	$25,932,991
Shared costs of the health system	$486,368	$496,096	$506,018	$516,138	$526,461	$536,990	$2,581,702
GRAND TOTAL	**$5,472,397**	**$15,877,679**	**$16,521,968**	**$30,550,505**	**$28,827,583**	**$28,920,483**	**$120,698,218**

A brief analysis of this table shows that the requirements of the program are estimated to be 120.7 million USD for the period, starting with 15.9 million USD in 2011 to rise to $ 28.9 million USD in 2015. The requirements for routine activities total 94.8 million USD; that is more than three quarters (78%) of the total while the requirements for campaigning are estimated to be 25.9 million. The estimated costs for 2015 are five times higher compared to the 2006 base year (5.5 million USD), when the EPI had not yet

introduced the new vaccines.

5.2 Financial gap analysis

For the first year (2013), the gap will be $13,697,992 USD; for 2014 and 2015, they will be approximately $15,718,683 USD and $17,963,668 USD. On this basis, if the GAVI proposal is accepted, and the funds are transferred, the grant from GAVI will reduce these gaps. To cover the rest of the gap, one must depend on the contribution of the national treasury and on international cooperation. However, with respect to international cooperation, in most cases, the lenders including the Centers for Disease Control and Prevention (CDC) cannot indicate their exact contribution yet for the future years.

5.3 Explanation and justification of the proposed budget:

The RSS budget covers the following sectors:
-Strategic and operational planning
-Monitoring/evaluation
-Staff training
-Collection, analysis and utilization of data
- Infrastructures and equipment
-Community activities
-Availability of quality health care services
Vaccines and logistics, cold chain, and epidemiological monitoring are not taken into account in the RSS budget as they are covered by specific funding from GAVI (new vaccines), UNICEF, the CDC and the tripartite cooperation (Brazil/Cuba/Haiti).
The activities are planned considering the integration so as to avoid duplications and try to have complementary interventions.

Program Funding.

Tables 1 and 2 of the "Common Proposal Form for Request for Support" present the funding by the counterparts for the years 2013 to 2015 as well as the sectors of support through this funding.

The funding sources currently available for the EPI, which should continue during the following years, and the categories for which they are intended are as follows :

- The **national budget** is and will be responsible for: The **general costs of functioning and maintenance of services** at the central level (DEPI) and the departmental level (DDS) and the **salaries and payments of officials** at the central/national, departmental and operational level.

- **The Public Health Organization/World Health Organization and UNICEF** are and will be responsible for, until 2015 through the EPI Support Project (PAPEV), a joint project funded by **Canada**, the **salaries of contract staff** for strengthening at the central or national level, if required, costs of **support activities /monitoring of the departmental level** by the center: supervision of regions, national workshops on monitoring and planning, departmental supply of vaccines and inputs, installation and repair of refrigerators and activities of technical assistance for training and workshops (monitoring and planning) organized by the DDS for institutions, costs of **training and recycling of national and departmental frameworks and institutional and community service providers**, costs of **epidemiological monitoring** (investigation of cases and active research), renewal of **logistical resources** (vehicles and motorcycles), purchase and installation of **incinerators** and **operational research** related to ensuring the geographical accessibility of the EPI, community participation, integration of immunization in the first level Minimum Services Package and motivation of personnel.

- **UNICEF** is and will be responsible for, with the funding by the Japan International Cooperation Agency **(JICA) the actual vaccines and related inputs**, including those related to waste management and the purchase and renewal of active and passive **cold chain equipment**.

- The **Tripartite project Brazil-Haiti-Cuba**, in addition to providing technical assistance, will be responsible for the purchase of vaccine and cold chain equipment.
- The CDC provides and will provide the funding for the strengthening of the cold chain (purchase of 124 solar chill refrigerators and the training of personnel), the purchase and transport of new vaccines, the training of personnel and salaries of contract personnel at the departmental level, and the strengthening of the epidemiological monitoring for new vaccines.
- The **NGOs**, in particular, those that depend totally or partially on the United States Agency for International Development **(USAID)** are and will be responsible for **salaries and related costs of personnel and institutional service providers**, **awards made to community staff** responsible for the implementation and supervision of the advanced strategy in several communes distributed across the departments.
- **Institutions with private or mixed status** are and will be responsible for personnel and costs of transport of vaccines and inputs, including gas, from the departmental warehouses.
- **GAVI:** Funds sought from GAVI are:
    - Funding of new vaccines
    - GAVI-HSS Project; and
    - Funding for the introduction of new vaccines to the tune of $100,000 USD.

6. 6. Implementation Arrangements, Capacities, and Program Oversight

6.1 a) Lead Implementers (LI)

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

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

Lead Implementers (LI):	MPHP
Objective(s):	1) Coordinate the process of drafting the GAVI-HSS proposal 2) Coordinate the technical, managerial, and financial implementation of the HSS plan

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

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The Lead Indicator for the HSS plan is the Ministry of Public Health and Population which has delegated this function to the Directorate of the Expanded Program on Immunization DEPI.
The DEPI is a central directorate of the MPHP governed by a Director who holds a Master's degree in Public Health or one who has held management positions at the central or departmental levels for at least 7 years.
The Director is assisted by a Deputy Director who is responsible for the coordination.
The DEPI consists of 5 divisions;

- Administrative division whose duty is to ensure human resources management of the Directorate.
- Field Operation division whose responsibilities include planning, monitoring and training supervision, coordination and monitoring of the supervision missions.
- Logistics, Cold chain, and the Vaccine Management division
- Statistics and IT division
- Epidemiological Surveillance division

The DEPI will ensure the technical management of the project through its service structures and with the technical support of various partners incorporating the ICC and the EPI Technical Committee.

In 2011, all activities implemented by the DEPI, in collaboration with its key partners, resulted in an annual budget of approximately $12 million USD. The DEPI has the experience of managing multiple international projects – PAPEV which is funded by CIDA and the Tripartite cooperation. It currently manages, with the support of PAHO / WHO, a GAVI Grant for the introduction of new vaccines. It monitors nearly 600 institutions that administer routine immunizations.

Lead Implementers (LI):	WHO/PAHO
Objective(s):	1) Monitoring / technical and administrative support. 2)Technical support for the implementation and monitoring of the GAVI-HSS proposal 3) Technical, administrative and financial controls

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

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The PAHO/WHO as specialized Agency of United Nations System in the healthcare sector has the technical capability required for the administrative and financial management of this project. This experience in project management has already been proven in the context of GAVI-HSS support (for the introduction of new vaccines) as in other local or international projects.

The bi-annual cooperation plan signed between PAHO / WHO and the MPHP and based on Strategic Cooperation, CCS 2013 is in perfect harmony with the broader objectives defined in the plan proposed by the MPHP. For this reason, immunization is one of the most important aspects of cooperation between the two entities.

The Representative of the PAHO/WHO in Haiti is an international consultant recruited and inducted as a permanent staff member to provide support to the National Immunization program and is assisted by an administrative assistant. He is assisted in its activities by another international consultant specifically responsible for the EPI support through a project funded under the Canadian Cooperation (PAPEV). In addition, the EPI team for PAHO / WHO has recruited a national consultant with proven experience in management of immunization services. He also plays a vital role in establishing a permanent liaison with the EPI team of the MPHP.

With regard to administrative and financial matters, assessments and audits carried out within the office will earn him good reputation in these areas.

6.1 b) Coordination between and among implementers

→ *Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.*

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The management of HSS support funds will be jointly executed by the PAHO/WHO and the MPHP.

As part of this joint management, the funds will be transferred to the account of the PAHO / WHO.

Prior to any disbursement, the two entities must establish an Annual Work Plan (AWP) whose contents will be used to prepare the budget.

The disbursement process will be initiated by the drafting of a letter of agreement signed between the Minister and the representative of PAHO / WHO in Haiti. The letter of agreement must state in detail the activities to be performed and the amounts that are specifically assigned, the conditions relating to the management of funds and the justification of expenditures. Once the letters of agreement are signed by the concerned authorities, based on requests from the administration of the MPHP, the transfer of funds will be executed by the PAHO/WHO in favor of the directorates and departments involved in implementing the HSS plan.

As the Ministry of Public Health and Population and PAHO / WHO are the two entities responsible for the management and administration of funds, the coordination between them shall be ensured through quarterly meetings during which the MPHP shall present the financial reports for the funds received. These reports will be consolidated by PAHO / WHO, who will be responsible for forwarding them to the concerned authorities.

The ICC meetings will also serve as a framework for monitoring the budget execution in collaboration with other partners involved.

6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*

(i) (i) Will other departments, institutions or bodies be involved in implementation as Sub-Implementers?	◉ Oui *→go to section 6.1 c) (iii) and 6.1 c) (iv)* ○ Non *→go to section 6.1 c) (ii)*

(ii) If no, why not?

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(iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe:

- The roles and responsibilities to be fulfilled;
- Past implementation experience;
- Geographic coverage and a summary of the technical scope;
- Challenges that could affect performance and mitigation strategies to address these challenges.

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6.1. iii)

(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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The private sector and civil society are not the direct sub-implementing entities. However, their contribution to the activities related to the development of the health system in general and the immunization program in particular is not insignificant. As such, it should be noted that the functioning of nearly half of the country's health institutions is the initiative of charity institutions or non-governmental organizations working in collaboration with the MPHP. In addition, as far as the national immunization program is concerned, in a special way, the organized groups of the civil society, including community-based organizations, the Haitian Society of Pediatrics, the International Red Cross, Rotary Club, are all partners of the DEPI in the execution of activities under its annual plans.

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
→ *add extra rows as needed*	N/A			

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

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N/A

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

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The two main entities of execution (MPHP, PAHO / WHO) have sufficiently qualified technical staff to ensure the implementation of this HSS plan. In the past, they had to jointly manage projects and they did so successfully, especially projects related to GAVI support (HSS 2009, introduction of new vaccines in 2011) or in other projects such as PAEPI.

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

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The funds for Strengthening of the Health System will be transferred to the account of the Public Health Organization /World Health Organization (PAHO/WHO) located in Washington. For the implementation of activities, the disbursements will be done on the basis of requisitions from the management unit in order to cover the requirements defined in the framework of the action plan (national and departmental) in accordance with the procedures established by PAHO/WHO for all activities of technical cooperation.

On a technical level, each institution that is responsible for the implementation of the activities of the proposal will create a report on the activities carried out during the year. Each report will be drafted on the basis of the objectives included in the approved annual action plan.

The officials of the regional health departments are responsible for monthly evaluation and checking of the utilization of funds as well as adherence to processes in each region. At the central level, the activities are the responsibility of the Administration and Budget Department of the MPHP. In collaboration with the PAHO/WHO, the Administration and Budget Department will also be responsible to monitoring and financial control of the regions.

Every six months, an internal audit will be carried out at the central level as well as in each region by a joint team from the Administration and Budget Department and PAHO/WHO. Finally, at the end of each year, an external audit will be carried out by an independent agency followed by feedback to all concerned participants.

Governance and oversight arrangements

➔ *Please describe :*

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

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

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

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The MPHP represents the national health authority that sets the major strategic orientations of the health sector through its Master Plan (attachment 7). The Strengthening of the Health System is a result of this Master Plan and the principles of its governance are validated by the CCIA which is a structure for the support of the national immunization program.

The CCIA is a body responsible for the coordination and monitoring of the EPI. It is defined in the EPI documents as the body resulting from the collaboration between the MPHP and its partners for the successful development of the program. This collaboration concerns the following shared activities:

- the drafting of the multi-year EPI Strategic Plan
- harmonization of the requirements with the available resources at the national and international level
- The mobilization of resources necessary for the funding of EPI
- The monitoring of the sufficiency of budgetary allocations against the importance of activities and their risks
- The monitoring and evaluation of the execution of the EPI's multi-year Strategic Plan
- The validation of strategic and operational plans as well as reports.

The coordination of the support of GAVI provided for the Strengthening of the Health System will be done by the same body which also supported the team responsible for the drafting of the proposal.
The CCIA consists of representatives from the agencies that provide technical, financial and material support to the EPI. It is headed by the Minister of Public Health and Population while the secretariat is provided by the Director of the EPI. This Committee conducts ordinary meetings every 2 months and additional meetings on an as-needed basis.

The CCIA is supported by the EPI Technical Committee in the decision-making process (technical expertise).

The EPI Technical Committee is a body consisting of technical experts of the MPHP and partners in the domain of immunization and public health in general. Its mission is to provide technical assistance to the administration of the National Immunization Program in terms of policy and strategic choices and the steering of the program.
In accordance with the above, the EPI Technical Committee is responsible for:

- Supporting the revision and update of the immunization schedule;
- Formulating the recommendations for the introductions of new vaccine;
- Formulating the recommendations related to the target groups considered during the process of elimination and eradication of diseases preventable through immunization.
- Responding to questions by medical and paramedical training schools with respect to the

national level decisions taken on immunization.

- Supporting the national program in preparing for the country's participation in important international meetings on immunization.
- Analyzing the documents (reports, plans) submitted by the national program to the CCIA and preparation of summaries with comments and recommendations for the members.

The composition of the EPI Technical Committee permits it to competently perform the functions assigned to it and develop the activities for which it is responsible. In addition, the Committee is composed of technical experts with skills and experience in the domain of public health, epidemiology, immunization, vaccines, cold chain and, if necessary, health economics so that its recommendations and the results of its analyses can be considered "the last word" to support strategic decisions to be taken by the Program or by the senior administration of the Ministry within the framework of the EPI.

Thus, the participation of the EPI is seen to be very active in the drafting of the proposal for support for the Strengthening of the Health System. It first assisted the consultant in defining the objectives which would result from the strategic orientations provided by the ministry and the CCIA.
The Technical Committee then participated in all the sessions for the review of the document before it was submitted for the signature of the Ministries of Health and Finances.
The CCIA played an important role in the process as it had to validate the proposal after the presentation of the basic structure by the DEPI.

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
Delay in the availability of funds for central and departmental services.	Provide clear and familiar disbursement procedures for participants at all levels. Define the periodicity for sending disbursement requests.
The important partners are unable to align the logic of their long-term policies or institutional priorities with the higher interests of the national immunization program.	Organize regular follow-up meetings of the CCIA and the EPI Technical Committee Take all measures to strengthening the leadership of the MPHP.
The occurrence of a catastrophe or epidemic for which the Haitian health system is not prepared and which would affect the capacity of management and resource mobilization for the funding of programs.	Defining a contingency plan Extraordinary mobilization of funds from other international agencies.

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.*

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This proposal is in perfect accordance with the national health policy and the Master Plan for 2012-2021. In addition, the objectives and activities of the Plan for Strengthening of the Health System will contribute to the achievement of objectives and execution of activities of annual operational plans resulting from the operationalization by the Master Plan. However, it is possible that the situations related to the implementation of the proposal might interfere with the development of other health programs. In this case, the coordination mechanisms between the different entities of the MPHP should be strengthened, and as far as possible through the Directorate-General.

Mandatory Attachments → *Please tick when the attachment is included*		
Document N°	*Attachment*	✓
1	National policy, national strategy, or other documents attached to this proposal, which highlight strategic HSS interventions	✓
2	Logframe	✓
3	National M&E Plan	✓
4	Performance Framework	✓
5	Financial gap analysis, detailed work plan and detailed budget	✓

Optional Attachments → *Please tick when the attachment is included*		
Document N°	*Attachment*	✓
6	Abbreviations and Acronyms	✓
7	2012-2021 Master Health Plan	✓
8	RED Municipalities	✓
9	2011-2015 PAP-EPI	✓
10	Performance Indicators	✓
11	New vaccine introduction plan	✓
12	Minutes of the ICC meeting dated August 29, 2012	✓
13	Supplement to the request for support	✓
14	Supplement to the HSS support request with signatures	✓