REPUBLIC OF GUINEA

HEALTH SYSTEM STRENGTHENING SUPPORT FOR THE REPUBLIC OF GUINEA

Date of request: September 2, 2009

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Nouvelles demandes / New Proposals
GAVI Alliance Secretariat,
Chemin de Mines 2.
CH 1202 Geneva, Switzerland

Conakry, August 2009

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To the applicant:

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

Abbreviations and acronyms

AFD	: French Development Agency
AFRO-HQ	: Regional Office for Africa – Headquarters
AGBEF	: Guinean Association for Family Welfare
SNHDP	: Support to National Health Development Plan
ARV	: Antiretroviral
THA	: Technical Health Agent
ADB	: African Development Bank
BCG	: Bacille Calmette-Guerin
IDB	: Islamic Development Bank
WB	: World Bank
SDO	: Strategy and Development Office
IACC	: Inter -Agency Coordinating Committee
HSCC	: Health System Coordinating Committee
CC	: Cold Chain
MTEF	: Medium Term Expenditure Framework
IDRC	: International Development Research Center
CNFRSR	: National Center for Training and Research in Rural Health
NHA	: National Health Accounts
CPC	: Primary Curative Consultation
ANC	: Antenatal Consultation
CREDES	: Center for Health Research and Development
HC	: Health Center
TCC	: Technical Coordinating Committee
DHTC	: District Health Technical Committee
RHTC	: Regional Health Technical Committee
FAD	: Financial Affairs Division
TSM	: Technical Support Mechanism
DOTS	: Directly Observed Therapy – Short-course
DHD	: District Health Directorate
RHD	: Regional Health Directorate
HD	: Health District
PRSP	: Poverty Reduction Strategy Paper
DTP	: Diphtheria Tetanus Pertussis
DTP/HepB/Hi	: Diphtheria Tetanus Pertussis/Hepatitis B/Haemophilus Influenzae
ECD	: Equipe Cadre de District [District Management Team]
DHS	: Demographic and Health Survey
GAVI	: Global Alliance for Vaccines and Immunization
GIVS	: Global Immunization Vision and Strategy
GTZ	: German Cooperation Agency
Hep B	: Hepatitis B Vaccine
HGR	: Reference General Hospital
NH	: National Hospital
DH	: District Hospital
RH	: Regional Hospital
AH	: Arterial Hypertension
HDI	: Human Development Index
IFORS	: Institue for Health Taining and Research

ARI	: Acute Respiratory Infection
STI/HIV/AIDS	: Sexually Transmittable Infection/Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IST/WA	: Inter-country Support Team – West Africa
ED	: Essential Drugs
MESRS	: Ministry of Higher Education and Scientific Research
METFP	: Ministry of Technical Education and Professional Training
MICS	: Multiple Indicators Clusters Survey
ITBN	: Insecticide-Treated Bed Nets
MSHP	: Ministry of Health and Public Hygiene
MURIGA	: Community Health Insurance for Safe Motherhood
NC	: New Contact
MDGs	: Millennium Development Goals
WHO	: World Health Organisation
NGO	: Non-Governmental Organization
OAP	: Operational Action Plan
PCG	: Guinea Central Pharmacy
IMCI	: Integrated Management of Childhood Illness
EPI-PHC-ED	: Expanded Immunization Plan-Primary Health Care-Essential Drugs
FP	: Family Planning
AFP	: Acute Flaccid Paralysis
PIP	: Public Investment Program
PIP-TCP	: Public Investment Program-Technical Cooperation Program
MPA	: Minimum Package of Activities
FMPA	: Full Minimum Package of Activities
NHDP	: National Health Development Plan
UNDP	: United Nations Development Program
cMYP	: Comprehensive Multi-Year Plan
DHDP	: District Health Development Plan
HIPC	: Heavily Indebted Poor Countries
HP	: Health Post
PMTCT	: Prevention of Mother To Child Transmission
GPHC	: General Population and Housing Census
HR	: Human Resources
GNI	: Gross National Income
HSS	: Health System Strengthening
PAC	: Post Abortion Care
FAS	: Financial Affairs Service
ACSDS	: Accelerated Child Survival and Development Strategy
SERACCO	: Regional Service for Support to Collectivities, Cooperatives and NGOs
MCH	: Maternal and Child Health
NHIS	: National Health Information System
EONC	: Emergency Obstetrical and Neonatal Care
BEOC	: Basic Emergency Obstetrical Care
CEOC	: Comprehensive Emergency Obstetrical Care
RH	: Reproductive Health
HSSS	: Health System Strengthening Strategy
HS	: Health System
STEP	: STEPwise Approach
TB	: Tuberculosis
IPT	: Intermittent Preventive Treatment
UNFPA	: United Nations Population Fund
UNICEF	: United Nations Children's Fund
USAID	: United States Agency for International Development
USD	: US Dollar
MV	: Measles Vaccine
TT	: Tetanus Vaccine

Executive summary

To the applicant:

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

Located in West Africa, the Republic of Guinea, with a population estimated at 10,235,747 inhabitants in 2009, is ranked among the heavily indebted poor countries. Forty-nine percent of the population lives under the poverty threshold. The epidemiological profile of the country remains dominated by endemic diseases, notably malaria, diarrheal diseases, intestinal parasitoses, acute respiratory infections, sexually transmittable diseases, malnutrition, oral diseases, and various traumas. Data on the health status of the population are characterized by an infant mortality rate[1] of 91 per thousand, a rate of infant-juvenile mortality[2] of 163 per thousand and a maternal mortality rate[3] of about 980 per 100,000 live births; life expectancy at birth is around 54 years.

DTP3 vaccine coverage rate is 88% according to 2008 administrative data.

To reduce the burden of morbidity and mortality, the Ministry of Health and Public Hygiene has developped, in collaboration with sector stakeholders, the following strategic documents:

1) The National Health Development Plan (NHDP) has for general objective to put in place, by 2012, a health system accessible and capable to answer the health needs of the population and to contribute to poverty reduction;

2) The cMYP covering the period 2007-2011 fits within the framework of the implementation of the strategic axis nº 1 of the NHDP. Its general objective is to contribute to the reduction of morbidity and mortality due to vaccine-preventable diseases by improving the rates of vaccine coverage for all the antigens of the Expanded immunization Program (EPI) and strengthening surveillance of all diseases with epidemic potential.

But attainment of these objectives is limited by health system constraints. These are: (i) the low accessibility of care and services, (ii) the low availability of drugs and human resources, (iii) the weak coordination of the sector and (iv) the under-financing of the sector.

Indeed, despite the efforts of the Ministry of health and its partners to eliminate these constraints, mostly in acute poverty and post-conflict zones, 15 health districts out of 33 show various difficulties in implementing care provision and immunization activities.

The current application to GAVI comes in complement to other interventions to eliminate these obstacles in five (5) districts selected based on the following criteria: (i) complementarity of external interveners, (ii) concentration of GAVI support in a single geographic zone to avoid dilution of efforts, (iii) potential for results in essential services coverage (immunization and other health services) and (iv) optimization of monitoring costs.

For this purpose, two objectives were defined:

[1] DHS III 2005
[2] DHS III 2005
[3] DHS III 2005

1. To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage
2. To strengthen management capacity in 5 health districts, 2 regional health directorate and at the central level by the end of 2011

To achieve these, the following intervention areas have been targeted:

- improving of essential health services accessibility by organizing advanced strategies (mobile maternal and child health care) in isolated villages,
- strengthening the quality of service provision and implementing mechanisms of disease risk sharing. These 2 areas are included in the NHDP strategic axes nº 1 and 3.
- strengthening management capabilities at all levels of the health pyramid through training of personnel in planning, health services monitoring and evaluation and development of supervision (NHDP strategic axis nº 2)
- strengthening coordination, inter-sectorial collaboration and community participation (NHDP strategic axis nº 2 and 5)

The total poulation of the 5 targeted district is 1,046,2345 inhabitants in 2009.

The global support of GAVI over two years from 2010 to 2011 will amount to **2,133,932** USD and will complement already available financing (State, households, other partners).

Accomplished progress will be evaluated through the following indicators: vaccine coverage rate, curative services usage rate by children under 5, assisted delivery rate and C-section rate. At this stage, available data are not disaggregated by gender.

With the objective to ensure a better utilization of GAVI funds, audits will be initiated by the HSCC. The Ministry of Health and Public Hygiene will collaborate with GAVI secretariat to ensure that the transparency and accountability policy (TAP) of Guinea conforms to required criteria. Results of each audit will be discussed at the level of the HSCC to take the necessary actions to correct eventual deficiencies in funds management.

The implementation by the government of current reforms undertaken in the health sector will ensure sustainability of gains derived from GAVI support. These are: (1) the transfer of basic health services (health centers and posts) to local collectivities (2) the improvement of technical management and governance capabilities (3) the improvement of the quality of service provision and (4) the promotion of the mutual health insurance association movement.

Section 1: Application Development Process.

To the applicant: section 1.1

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

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

1.1 : The HSCC (or country equivalent)

Name of HSCC (or equivalent): Health System Coordinating Committee (HSCC).
The HSCC has been created by memorandum nº 156/MSHP/CAB on September 19, 2008.

The HSCC is operational since:

The Health System Coordinating Committee of the Republic of Guinea is operational since the month of November 2008 through the implementation of a technical committee in charge of developing the HSS application of the Republic of Guinea and the organization of process follow-up meetings.

Organisational structure (e.g., sub-committee, stand-alone):

The Health System Coordinating Committee is presided by the General Secretary of the Ministry of health and public hygiene. In addition to the president, it includes a vice-president, a secretary and twenty-one members from ministerial departments and national institutions and from international partners of the Ministry of health and public hygiene.

In addition, a technical committee in charge of developping the application has been created by memorandum nº 155/MSHP/CAB on September 19, 2008. Presided by the chief of staff of the Ministry of health and public hygiene, it includes one vice-president and eight (8) members.

The Health System Coordinating Committee may also request external assistance if needed.

It is worth remembering that mechanisms of coordination of the implementation of the NHDP have been set-up and are operational since 2003. These are the District Technical Health Committees (DTHC), the Regional Technical Health Committees (RTHC), the Technical Coordinating Committees (TCC) and the annual meeting of technical and financial partners.

Frequency of meetings:[4]

Ordinary meetings of the health system coordinating committee take place quarterly. The first meeting of the year is a meeting of action plans validation and the last one focuses on the annual review of interventions and resources utilization and on the definition of the following year priorities.

Extraordinary meetings may be called if necessary.

Role and function:

The Coordinating Committee has the following roles:

[4] Minutes from HSCC meetings related to the HSS proposal preparation should be attached as supporting documentation, together with the minutes of the meeting where the application was endorsed by the HSCC. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

1. to define and ensure the follow-up of political and strategic orientations and of health system reforms;
2. to monitor the implementation of the NHDP and the PRSP according to the country health policy;
3. to mobilize internal and external (multilateral and bilateral) resources needed for the health sector financing;
4. to ensure coordination, aligning and harmonization of interventions in the health sector;
5. to validate results of the Technical Committee work;
6. to organize annual reviews and coordinating bodies of the health sector;
7. to approve plans and annual reports of the health sector;
8. to initiate audits of financial resources management in the sector and to validate their results;
9. to initiate evaluations in the sector and to validate their reports;
10. to validate internal and external evaluation reports.

To the applicant: section 1.2

- *In this section, please describe the process your country followed in preparing this GAVI HSS application (Table 1.2)*

Note: Without supporting documentation (signed minutes from HSCC meetings) and a thorough outline of the process of preparing the application it will not be possible for the GAVI Independent Review Committee (IRC) to assess the involvement of key stakeholders (civil society, bilateral, private sector and representatives from hard to reach populations) in the process. The signed minutes of the HSCC meetings related to the HSS proposal preparation should be attached (Document Number....) as supporting documentation, together with the signed minutes of the meeting (Document Number....) where the application was endorsed by the HSCC.

1.2 : Overview of application development process

Who coordinated and provided oversight to the application development process?

The health system coordinating committee coordinated and provided oversight to the application development process.

Who led the drafting of the application? Was any technical assistance provided?

The writing of the application was led by the chair of the application development technical committee in collaboration with the Strategy and Development Office of the Ministry of health and public hygiene, which is the unit in charge of the coordination of the technical secretariat.
WHO provided an international consultant to the Ministry of health and public hygiene, who supported the application development process.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

The application development process proceeded as follows:

- September 19, 2008: Creation of the Health System Coordinating Committee (HSCC).
- September 19, 2008: Creation of the technical committee in charge of developping the health system funding application to GAVI-HSS.
- November 21-29, 2008: Preparatory workshop in Conakry to define the methodological process, the steps, the time-line and the budget of the development process of the HSS funding application to GAVI and the document review. This workshop benefited from an international consultant recruited by WHO Regional Office for Africa;
- December 1, 2008: Meeting to report to the Coordinating Committee the results of activities at the November 21-29, 2008 preparatory workshop.
- December 9-11, 2008: Participation in Ouagadougou of a team comprising the directors of the strategy and development office and of the EPI, a dictrict chief medical officer and the head of health system strengthening at WHO representation in Conakry to the capacity strengthening workshop on GAVI-HSS application development.
- January 7-22, 2009: Workshop in Maferinyah (100 km from Conakry) to develop the first draft of the application by filling the form on the basis of the following elements:

- analysis of available information and identification of bottle-necks or barriers that hinder performance of the health system;
- identification of barriers that are being managed satisfactorily with the existing resources;
- identification of barriers that are not being managed satisfactorily and that will need GAVI HSS support;
- choice of zones and interventions to submit to GAVI for financing;
- estimation of costs and definition of the implementation and monitoring framework.

- February 5, 2009: Meeting to report to the Coordinating Committee the results of activities at the workshop to develop the first draft of the application;
- February 16-18, 2009: Organization of a regional workshop at Maferinyah to amend the first draft of the application by intermediary and peripheral tiers of the health system;
- March 12, 2009: Submission of the finalized first draft for review by peers (IST-WA, AFRO-HQ) and key partners;
- March 17-19, 2009: Participation in Ouagadougou of the directors of the strategy and development office and of the EPI, the HSS/Global Fund focal person and the head of health system strengthening at the WHO representation in Conakry to the workshop on GAVI-HSS applications peer-review for 5 French-speaking countries in west Africa.
- March 30 – April 4, 2009: Workshop to develop the second draft of the GAVI-HSS application by the Technical Committee taking into account the observations formulated during the first draft peer-review workshop;
- April 5-15, 2009 Inclusion of observations made by peers and key partners supported by an international consultant;
- April 15, 2009: Meeting of the HSCC for adoption and approval of the application.
- April 17, 2009: Final document signing ceremony;
- April 24, 2009: Transmittal of application to GAVI executive secretariat.
- June 2009: Assessment of the application by the Independent Review Committtee
- July 31, 2009: Meeting to report to the Coordinating Committee the results of the assessment of the application by the Independent Review Committtee;
- August 04-09, 2009: Organization of a workshop to prepare the new submission to GAVI-HSS;
- August 17-19, 2009: Participation in Ouagadougou of two senior managers to the peer-review of tentative answers to submit to the IRC
- August 21, 2009: Meeting of presentation of the new application
- August 24-25, 2009: Inclusion of observations formulated during the August 21, 2009 meeting
- August 26, 2009: Meeting of approval of the new application
- August 28, 2009: Signing of the new application by the ministers
- September 2, 2009: Transmittal of the new application to GAVI executive secretariat.

Who was involved in reviewing the application, and what was the process that was adopted?

The organizations that were involved in reviewing the HSS application of the Republic of Guinea are:

1. WHO (country office)
2. UNICEF (country office)
3. UNFPA
4. AGBEF
5. Ministry of Economy and Finance
6. Ministry of Planning and Private Sector promotion

The review process of the HSS application of the Republic of Guinea was as follows:

1. each version emanating from a drafting workshop was sent to members of the HSCC and to partners for suggestion of corrections or comments.
2. after receipt of comments on the various versions of the document, a meeting was organized to allow all involved to operate changes they judged necessary.
3. following this process, the final version of the document is produced and sent to GAVI executive secretariat.

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

Before its submission to GAVI secretariat, the application of the Republic of Guinea was approved by:

1. The Minister of Health and Public Hygiene
2. The Minister of Economy and Finance
3. The Minister of Planning and Private Sector promotion
4. The President of the Health System Coordinating Committee
5. The WHO representative, country office
6. The UNICEF representative, country office
7. The UNFPA representative, country office.

Was funding received from GAVI for HSS proposal development? If so, how much, when was it received, and what was it used for, or what will it be used for?

The Ministry of Health and Public Hygiene obtained 50,000 USD from GAVI to support the proposal development process. These funds were used to finance the proposal development workshops, the step meetings for results validation and to pay consultants who came to support the technical team developping the proposal.

To the applicant: section 1.3

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

Note: All key partners should be included in the process: the Ministry of Health, including the planning department and the immunization unit; Ministry of Finance; bilateral and multilateral partners; relevant coordinating committees; NGOs and civil society; and the private health sector. If there has been no involvement of civil society, the private health sector or other key stakeholders in the development of the GAVI HSS application, please explain this below (1.4).

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

Title / Post	Organization	HSCC member yes/no	Please list the specific roles and responsibilities of this partner in the GAVI HSS application development
Chief of Staff	MSHP	Yes	Coordination of proposal development process
Director of Strategy and Development Office	Ministry of Health and Public Hygiene	Yes	Preparation and management of the development process of the proposal of the Republic of Guinea
Director of Expanded Program on Immunization	Ministry of Health and Public Hygiene	Yes	Support to proposal development and harmonization of interventions with the cMYP
Director of Financial Affairs Division	Ministry of Finance	Yes	Contribution to proposal development and integration of aspects related to financing
Adviser on health system (MPN/OMS/RG)	World Health Organization	Yes	Technical support to HSS proposal development and partners mobilization
Head of Health Program/UNICEF	United Nations Children's Fund	Yes	Technical support to GAVI HSS proposal development and review before submission to GAVI Alliance
Adviser on Health Policy	MSHP	Yes	Support to GAVI proposal development team
Head of Human Resources Division	MSHP	No	Contribution to proposal development and inclusion of Human Resources dimension
Director of Guinea Central Pharmacy	MSHP	No	Contribution to proposal development and inclusion of Drug procurement dimension
Executive Director	AGBEF	Yes	Participation to coordinating bodies (PCC, TCC, Annual review) - Technical support to improve RH services - Contribution to proposal development and inclusion of civil society organization, population sensitization and private providers participation dimensions.
RH program lead	UNFPA	Yes	- Participation to coordinating bodies - Contribution to proposal development and inclusion of RH dimensions

To the applicant: section 1.4

- *Partners and members of the HSCC are encouraged to provide feedback and let the GAVI secretariat know of any concerns or anticipated issues with implementation, monitoring or financial arrangements.*
- *If the HSCC wishes to make any additional comments or recommendations on the GAVI HSS application to the GAVI Secretariat and Independent Review Committee, please do so below.*
- *Please explain if there has been no involvement of civil society or the private sector, and state if they are expected to have a service provision or advocacy role in GAVI HSS support implementation*
-
- *If this is a resubmission, please describe what were the main changes introduced for this proposal*
- *Please describe any lessons learnt or useful practices developed during HSS proposal development*

1.4: Additional comments on the GAVI HSS application development process

Most health sector partners (bilateral and multilateral cooperation, United Nations system and civil society) have been involved in the development process and the review of the proposal of the Republic of Guinea.

The private sector is relatively recent in the Republic of Guinea and the representation structures are not very operational.

Section 2: Country Background Information

To the applicant: section 2.1

- *Please provide the most recent socio-economic and demographic information available for your country. Please specify dates and data sources. (Table 2.1). If these differ from or are inconsistent from those used in other GAVI applications or monitoring, justification should be provided*

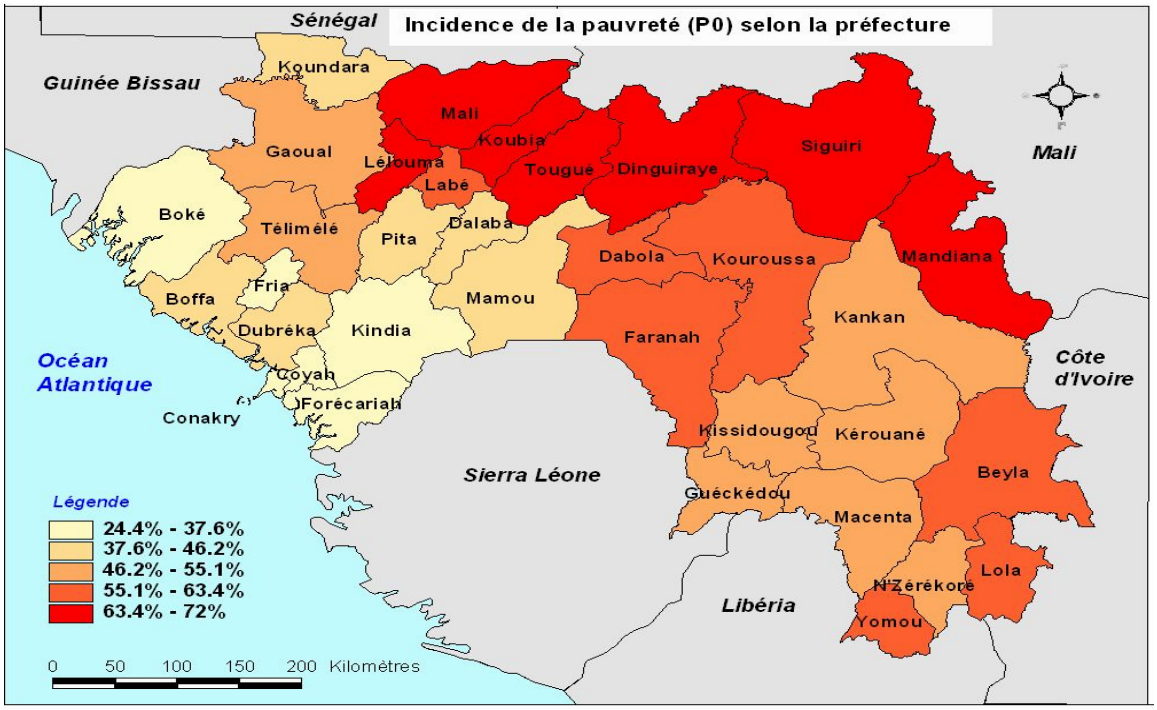
2.1: Current socio-demographic and economic country information[5]

Located in western Africa, the Republic of Guinea covers an area of 245,857 square kilometers. It comprises four natural regions, which are Lower Guinea, Mid-Guinea, Upper Guinea and Forested Guinea. Guinea is organized in 8 administrative regions including 33 districts and 5 municipalities.

Projection of data from the General Population and Housing Census conducted in 1996 allows to estimate that in 2009, with an annual population growth of 2.8%, Guinean population is 10,235,747 inhabitants.

Three Guineans out of 4 are illiterate, with rate much higher in women than in men and in rural populations than in urban ones.

Despite physical and economic potentials, Guinea remains among the least advanced countries. It has never been able to emerge from the block of the last 15 countries since the inception of the global Human Development Report. It is also ranked among the Heavily Indebted Poor Countries (HIPC), the Low-Income Counries Under Stress (LICUS) and the Fragile States.



Basically, the standard of living of Guinean populations is not only precarious, but it does not seem to improve much. In fact, according to the results of the last national households survey, the poverty rate increased between 2002 and 2005, going from 49.2% to 53% compared to

[5] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.

40% in 1995, with one fifth of these living in extreme poverty. The per capita gross national income went from 450 USD in 2000 to 410 USD in 2002 and 400 USD in 2006.

The millenium development goals (MDG), to which Guinea subscribed in 2000, overlap perfectly with those of the last two sequences of the National Poverty Reduction Strategy (PRS). However, they are far from being reached considering the results obtained in this regard up to now.

Health financing remains low with an average of 4-5% of the total national budget over the last decade. Almost all public health priority programs like HIV/AIDS, STIs, malaria and onchocercosis are dependent on donors funding.

Besides limited financial means, other indicators are also weak such as the number of people per physician (8,323 people), per nurse (6,245) and per birth-attendant (20,876). The most qualified personnel practices in Conakry (29% of physicians, 59% of laboratory personnel, 100% of dentists and 61% of midwives). Other regions, in particular rural areas, have much less services available.

This situation is clearly reflected in the households perception of their ability to answer their health needs, on one part, and the evolution of the degree of satisfaction of health needs during the last few years. Indeed, according to EIBEP 2002-2003/DNS/MP, only 4.2% of Guinean households are in a position to respond more than adequately to their health needs and 18.9% just adequately . A little more than three fourths (76%) of them are incapable to address them adequately.

The Guinean health system in comprised of public and private sub-sectors.

The public sub-sector is organized in a pyramidal fashion and includes, from the base to the apex, the health post, the health center, the district hospital, the regional hospital and the national hospital.

The whole infrastructure displays various physical and operational stages, because of differences in their building time, the technological methods used and in their maintenance.

The private sub-sector includes, medical facilities on one hand and biopharmaceutical ones on the other. The types of facilities in the medical sub-sector are the nurse or midwife office, the physician office and the clinic. Concerning the pharmaceutical and biomedical facilities, they include outlets, private pharmacies, wholesale companies and clinical laboratories.

Main socio-economic and health indicators

Information	Value	Information	Value
Population	10,235,747 [6]	per capita GNI	400 USD[7]
Live births annual cohort	409,430	Under five mortality rate	163‰[8]
Surviving infants	377,506	Infant mortality rate	91‰[9]
Percentage of the GNI allocated to health expenditures	4%	Percentage of Government expenditures allocated to health	6%[10]
DPT3 coverage rate (by sex, where available)	88%[11]		

* Surviving infants = Infants surviving the first 12 months of life.

[6] Population estimated on the basis of the cMYP 2007-2011
[7] World Bank 2006
[8] cMYP 2007-2011
[9] PRSP II 2008-2010
[10] PRSP II 2008-2010
[11] EPI Report 2008

To the applicant: section 2.2

- *Please provide a brief summary of your country's Health Sector Plan (or equivalent), including the key objectives of the plan, the key strengths and weaknesses that have been identified through health sector analyses, and the priority areas for future development (Table 2.2).*
- *Please highlight any specific socio economic barriers to accessing immunisation services that may include hard to reach populations or any gender inequities*

2.2 : Overview of the National Health Sector Strategic Plan (Document Number 1) and how it relates to the cMYP (Document Number 12)

To address the population health needs, the Guinean Government has developped and adopted documents such as the national health policy from which were derived the national health development plan (NHDP), the health component of the poverty reduction strategy paper (PRSP), the comprehensive multi-year plan (cMYP) and the national road-map for reducing maternal and neonatal mortality. There is a complementarity link between these strategic documents.

Le National Health Development Plan (NHDP) is within the implementation framework of the national health policy and was the basis for the development of the PRSP and the cMYP.

The NHDP which was built on a sectorial situation analysis, includes goals to reach and implementation strategies.

2.2.1 Situation Analysis

This analysis identified problems that hinder the performance of the health system. The main ones are:

2.2.1.1 Problems related to health services

a. Sector institutional framework

The organization of the Ministry does not permit to attain the desired performance level. The multiplication of vertical programs and their weak integration hinder the organization of the work in decentralized facilities and healthcare services.

b. Resources

The weakness and/or the inadequate distribution of available resources (human resources, facilities and equipment, pharmaceutical products, financial resources) limits the system performance.

c. Management process

The coordination, planning cycle, quality of service delivery, and health information system show signs of dysfunction at the various tiers of the health pyramid.

2.2.1.2 Health problems of the population

The state of health of the population is alarming. Actually, maternal mortality rates (980 per 100,000 live births), infant mortality rates (91 per 1000 live births) and the rates of prevalence per 1000 of some diseases remain high: malaria 104.7, respiratory infections 53.5, helminthic infections 32.1, bloody diarrhea 5.8, and non-bloody diarrhea 15.8.

Some emerging (HIV/AIDS, arterial hypertension, diabetes, cervical cancer, etc.) and re-emerging diseases (tuberculosis, trypanosomiasis…) are taking a more and more important role in the epidemiological pattern of the country. So are road traffic accidents and toxicomany under all its forms.

2.2.2 Challenges

The main challenges that the health system needs to confront are:

- ✓ sustainability of gains, which will require renewed commitment and responsibility from the State, health professionals, communities and development partners. This commitment includes financing and decentralization of the system.
- ✓ fair access to care and health services so that each Guinean can benefit timely from the care required for its health condition.
- ✓ improvement of the quality of care and services with compliance with internationally recognized and socially accepted standards.
- ✓ control of malaria and emerging and re-emerging diseases, particularly STI-AIDS and tuberculosis, which require everyone's mobilization.
- ✓ securization of reproductive health products.

2.2.3 Opportunities

- ✓ Government political will to improve the health of the population,
- ✓ Overlap of the health system organization and the administrative zoning,
- ✓ Decentralization of the territorial administration, currently undergoing a strengthening process with partners support, could contribute to the acceleration of the health sector decentralization,
- ✓ Commitment of partners to accompany the health policy implementation.

2.2.4 Political Orientations

2.2.4.1 Vision

The ***vision*** is to ensure that each person living in Guinea is in good health. This implies universal access to quality health care in a health system oriented toward the satisfaction of needs of communities and supported by a partnership and a strong inter-sectorial collaboration.

Target

The objective is to put in place by 2012, a health system accessible and capable to answer the health needs of the population and to contribute to poverty reduction.

2.2.4.3 Strategic Axes

To reach the objective above, the five following strategic axes, all detailed in the National Health Development Plan, have been adopted:

a. Integrated control of disease and mortality
b. Strengthening of institutional and management capacities
c. Improvement of supply and utilization of services
d. Development of human resources
e. Health promotion

The strategic axis *Integrated control of disease* has adopted primary prevention measures for the control of diseases. For this purpose, immunization against vaccine-preventable diseases, pregnancy monitoring to identify at-risk pregnancies early, nutritional monitoring and supplementation of children under 5 and IEC will be strengthened.

Immunization is recognized as the intervention with the best cost-efficiency ratio and therefore remains the main instrument of disease control.

To deliver these immunization services, the MSHP has adopted the Expanded Immunization Program (EPI) as an implementation strategy.

The EPI objectives are:

- To ensure the adequate availability of essential vaccines: DTP, Polio, Tetanus, BCG, measles, yellow fever, hepatitis B,
- To reach total vaccine coverage of 90% of children under 1 and women of child-bearing age, including in poor and remote areas.
- To eradicate poliomyelitis in the medium term.

To reach these objectives, the Ministry of health has developped a cMYP which aim to contribute to reduce infant mortality by achieving a national coverage of 90% for each antigen and at least 80% in each health district.

During the period spanning this plan, Guinea proposes to improve current achievements of routine EPI and to introduce pentavalent vaccine (DTP-HepB-Hib combined).

Regarding surveillance and control of disease, this plan proposes to eradicate poliomyelitis in Guinea by 2010, to eradicate maternal and neonatal tetanus and to control measles.

The adopted strategies are conform to GIVS constitutive strategies and are adapted to the Guinean context. They underscore integration with other health interventions aiming to promote child survival. These are in paticular, vitamin A supplementation, insecticide impregnated bednets distribution, children deworming and promotion of clean deliveries.

Section 3: Situation Analysis / Needs Assessment

To the applicant: section 3.1

GAVI HSS Support: GAVI HSS support cannot address all health system barriers that impact on immunisation and other child and maternal health services. GAVI HSS support should look for opportunities to complement and leverage other funding for health system strengthening, as well as fill "gaps" in current health system development efforts, without duplication.

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

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

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

Note: Issues affecting the specific nature of reaching the hard to reach populations and increasing coverage within assessments or the National Health Plan should be highlighted (such as gender or other socio economic issues)

3.1: Recent health system or immunisation assessments[12]

Title of the assessment	Participating agencies	Main Themes	Main findings in terms of child mortality, immunisation coverage or health systems weaknesses	Dates
Human Resources in Health	Ministry of health, French cooperation	Situation analysis of human resources in health, health system and health policy, institutional stakeholders, management functions of human resources, HR priority problems	Low availability of human resources in rural areas p. 20-23	2006
Assessment of the health component of PRSP	Ministry of planning, Ministry of health, GTZ, UNDP	ED, Infrastructures, Human resources, Coverage, Health Information System, Financing, Care, Institutional strengthening	Low accessibility level to health care and services: - insufficient basic health infrastructure - high cost of ED - weak personnel motivation to move to poverty zones (p. 73) Dysfunction of sector management: - lack of appropriate mechanism to deal with issues of indigence - absence of career plan - slow pace of implementation of reforms (decentralization and deconcentration) - lack of drugs and vaccines	2006
Comprehensive Multi-Year Plan (cMYP)	Ministry of health, UNICEF, WHO, USAID, ROTARY CLUB	Immunization, vaccines, human resources, infrastructure, logistics	- Insufficient national and external financial resources to implement the health component of PRS. . - Lack of training of new agents in EPI management; - Job abandonment rate above 10% in some districts - Low level of involvement of private facilities in immunization activities	2007

[12] **Within the last 3 years.**

Title of the assessment	Participating agencies	Main Themes	Main findings in terms of child mortality, immunisation coverage or health systems weaknesses	Dates
			- Aging emergency generators at all levels and lack of automatic alarm recorders in the central cold-chain. - Low storage capacity at positive temperature for the introduction of new vaccines (p32)	
Rapid assessment of health districts operationality	Ministry of Health, WHO	Health coverage, HS governance, essential resources, coordination	According to the assessment of health districts operationality conducted by the ministry of health, with support from WHO, in 12 districts out of 38, in November 2007, there is a low accessibility level to health services by the population, health facilities are under-equipped and there is a deficit of human resources in rural areas. In addition, several facilities cannot deliver the FMPA including immunization services, in particular private facilities.	2007
Study on secure drug purchase funds	ADB, Ministry of Health, CREDES, WHO	Accessibility, availability, financing of drugs	- High cost of drugs in the private sector - Currency depreciation - Low social coverage level (less than 5%) - Divided orders for import - Inappropriate price structure - Low level of penetrance of generic drugs in the private sector - Absence of price control - Lack of enforcement of the National Pharmaceutical Price-List (TPN) as intended in the pharmaceutical bill - Lack of enforcement of the regulation on social drugs - Lack of exemption of customs tariffs and fees on medical devices and reagents - Lack of compensation funds to stabilize prices	2007

Title of the assessment	Participating agencies	Main Themes	Main findings in terms of child mortality, immunisation coverage or health systems weaknesses	Dates
Quality Competition	Ministry of Health, GTZ	• accessibility/availability • co-management/community participation • clients satisfaction • technical skills • economic behavior • continuous improvement	– at the HC level, more than 50% are performing well – general performance of district hospitals varies between 34 and 82% including 17 with a performance above 75% – performance of DHD/CHD varied from 64% to 96% with an average of 78%.	
2006 health statistics yearbook	Ministry of Health, WHO	Activities, resources, morbidity and mortality indicators	- low curative care utilization rate : 0.3 new contacts/capita - low first ANC coverage rate: 73% - low rate of assisted deliveries: 18% with hospital at 4% and HC at 14%, - low DTP3 coverage rate: 79,6% - low C-section rate: 1,5% - long average length of stay: 7 d. - low average occupancy rate: 55%.	2007
			- Inadequate EDs consumables and vaccines procurement system and poorly operating equipment - Low quality of care and health services management, including planning, financial resources management and monitoring; - Inefficient operation of the referral and counter-referral system between community and health facilities on one hand and the various levels of health facilities on the other hand; - Limited financial, and sometimes geographical, acessibility to care, in particular hospital-based care;	

Title of the assessment	Participating agencies	Main Themes	Main findings in terms of child mortality, immunisation coverage or health systems weaknesses	Dates
National road-map for reducing maternal, neonatal and infant-juvenile mortality (2006-2015)	Ministry of health, WHO, UNICEF, UNFPA	Maternal mortality, under 5 child survival, traditional practices harmful to mother and child health, health financing and human resources	- Weak personnel motivation, absence of career plan; - Insufficient development and inadequate distribution/management of personnel in particular for midwives, obtetricians-gynecologists, surgeons and pediatricians in rural areas; - Limited capacity of referral facilities in particular for managing obstetrical and pediatric emergencies in district hospitals and for neonatal care in general - Lack of integration of RH services adapted to adolescents and young people in health facilities; - Shortage and under-utilization of operational research results in maternal and child health - Dispersion and shortage of communication activities for maternal and child health behavior change, and their monitoring and evaluation; - Weak coordination/integration of maternal and child health interventions at central and/or decentralized levels - low geographical coverage of health districts; - Lack of capitalization of best practices; - Weak institutional coordination of government sectors and partners around the NHDP and PRSP in particular for the various components of reproductive health and child health (page 18).	2008
			- weak capacity of human resources strategic management by the MSHP (forecast, productivity, distribution, etc.) - under-financing of the health sector and weak management capacity - low geographical health coverage	

Title of the assessment	Participating agencies	Main Themes	Main findings in terms of child mortality, immunisation coverage or health systems weaknesses	Dates
Cooperation strategy WHO-Guinea 2008-2013	Ministry of Health, WHO	Health system strengthening, disease control, emergencies and catastrophic situations	- dysfunction of the health information system - weak capacity for surveillance and for response to epidemics - low level of access to essential and quality generic drugs - high prevalence of transmittable and parasitic diseases - very high maternal mortality (980 death per 100,000 live births). - low rate of assisted deliveries (38%) - neonatal mortality is 39 per 1000 live births, - high infant and infant-juvenile mortality (91 and 163 per 1000 live births, respectively).	2008
Audit of the National Health Information System	Ministry of Health, Global Fund, TSM	Need for information, functions of the information system, resources	- weak statistical output capacity (yearbook, bulletin, performance indicators, health map etc.) ; - Insufficient completeness and timeliness of reports; - no system of control of the reliability of collected data; - insufficient data dissemination and utilization	2008
FAD Organizational diagnosis	Ministry of Health, Global Fund	Institutional framework, human and material resources, financial and accounting management tools and procedures	- inadequate work environment, insufficient quality and number of personnel, weakness of the financial management information system	2008
Nutritional survey and main indicators for child survival and development (MICS)	UNICEF, Ministry of health, Ministry of planning	Pregnancy and delivery monitoring, child health, bednets utilization, breastfeeding and feeding supplementation	- antenatal consultation rate: 88.4% - low rate of deliveries assited by a physician: 10% - low TT2 coverage rate: 68.7% - low DTP3 coverage rate: 43% - low rate of impregnated bednets utilization: 19%	2008

To the applicant: section 3.2

- *Please provide information on the major health system barriers to improving immunisation coverage that have been identified in recent assessments listed above. (Table 3.1). These could also highlight any socio economic or political reasons as well as men and women's roles in society, family or among workforce, attitudes towards boys or girls as well as 'perceptions' that may affect the immunisation coverage of specific ethnic groups or females and males.*

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

The document review performed for developing the HSS proposal has identified several bottlenecks to the supply of basic services including immunization services. This situation is characterized by low accessibility to care, low utilization of services, lack of drugs, inadequate distribution and demotivation of human resources, weak health interventions coordination and under-financing of the sector.

(i) Low accessibility to care

a. Geographical accessibility

According to the Rapid assessment of health districts operationality conducted by the Ministry of health, with WHO support, in 12 districts out of 38 in November 2007, the highest rate of populations living within a 5 kilometers radius of a health facility are noted in Matam (100%), Gueckedou (92%), Kankan (87%) and Kindia (87%). The lowest rates are noted in Dubreka (26%), Tougue (25%) and Koubia (21%). The proportion of covered population in a radius of 15 kilometers is usually above 70% except in Tougue (55%) and Faranah (57%).

The total number of integrated centers in the study zone is 124, including 122 operational ones, 120 with full MPA and 111 under public management. There are 257 first-contact health care facilities (health posts and private offices) including 251 fully operational, 233 with full MPA, 233 under public management, 13 under community management, six not-for-profit and two with only curative activities[13].

Despite efforts provided by the Government since 1988, some facilities do not yet respond to the technical and operational standards needed for adequate patients management.

According to the assessment of the Health component of the PRS, 19% of health centers are dilapidated; these are mostly located in Upper Guinea; 38% of district hospitals are in: Boffa, Gaoual, Dabola, Kouroussa Kerouane, Beyla, Lola, Yomou, Macenta and Kissidougou; 23% are not operational because they are dilapidated, lack space or were recently built and await personnel and /or equipment.

Although each region has an hospital, the technical expertise of these facilities remains weak and little operational. In addition, management and organizational procedures are not very efficient and hospital facilities are overwhelmed by activities that should be a matter for primary care level facilities.

The recent assessment of health districts operationality cited above showed that at the level of facilities and basic equipment, indicators of potentiality of health districts are in general very variable. The number of conference rooms and proper offices is quite important. A lack of

[13] Rapid assessment of health district operationality

informatics and communication equipment can be noted. Four districts out of twelve do not have a single computer.

b. Financial accessibility

A uniform costs recovery system is implemented in all regions of the country. Funds generated by this approach and re-infused in health services financing contribute to cover some expenditures like drugs, fuel for cold chain and advanced strategies and management tools.

Besides, over-charge has been instituted, market costs have increased significantly. Also, increase of the level of poverty (53.2% of the population is under the poverty threshold[14]) and the weak development of mechanisms of disease risk sharing in the country constitute a limit to accessibility and therefore lead to a low level of health services utilization.

(ii) Low level of services utilization

a. Curative care utilization

The 2006 statistics yearbook indicates that the rate of services utilization at the national level is 0.3 new contacts per capita per year;

At the health district level, the number of contacts per year and per capita varies between 0.18 (Koubia) and 0.43 (Dabola); which shows important differences[15].

b. Immunization services utilization

The analysis of the immunization system performed within the context of the cMYP 2007-2011 underscored un number of weaknesses and threats of the EPI such as the low level of utilization of immunization services by the community in some districst: 28% of health districts did not reach the 80% DTP3 coverage target, 26% did not reach 80% for MV and 385 for TT2+. In general, private health services do not contribute to immunization activities[16]. Advanced and mobile strategies financed by health facilities own resources are not regular either because of reductions in incomes or the weakness of the Governement contribution or because of insufficient human resources.

c. Utilization of other essential interventions

According to the 2006 statistics yearbook, the regions of N'Zerekore, Faranah and Kankan have obtained an antenatal consultation rate above 80% but, one notes that, for a complete 3 antenatal consultations schedule with one at month 9, no health region reached 40%.

Intermittent preventive treatment was recently adopted as a malaria complications prevention regimen in pregnant women. The adoption rate of this new approach does not go beyond an average 61% yet. The district of Dalaba holds the record (97%) in term of percentage of health facilities implementing IPT, followed by Koubia (94%) and Dabola (92%). The lowest percentage was observed in Gueckedou (27%).

The rate of assisted deliveies in Guinea is 18% corresponding to 14% by HC and 4% by hospitals. Therefore, 82% of deliveries happen out of the control of health facilities: births from these deliveries are not notified and managed in health facilities. This constitute a real barrier to reaching the MDGs in particular the maternal, neonatal and infant mortality reduction.

[14] Assessment of the health component of PRSP
[15] Rapid assessment of health district operationality
[16] cMYP 2007-2011

The rate of C-sections performed is 1.55 for the entire country. This rate is significantly inferior to the standard of 5%. However satisfactory rates were observed in some districts including Coyah at 4.8%, N'Zerekore at 3.2% and Dabola at 2.3%[17].

The lower rates are noted in the districts and municipalities of Kaloum, Dixinn, Matoto, Matam, Ratoma, Yomou and Mali at less than 1%.

The number of district hospital performing comprehensive emergency obstetrical care (CEOC) or having a surgical branch is very low (0.47 per 100,000).

The 2007 Quality Competition has revealed the performance of health facilities by tier of the health system. This performance was measured though the following dimensions: accessibility/availability, co-management/community participation, clients satisfaction, technical competencies, economic behavior and continuous improvement.

The following results were registered in 2007:

- at the HC level, more than 50% are performing well
- general performance of district hospitals varies between 34 and 82% including 17 with a performance above 75%
- performance of DHD/CHD varied from 64% to 96% with an average of 78%.

As all these indicators show, services are under-utilized and not performing well. The causes of this situation are the paucity of qualified personnel, the lack of adequate equipment for quality services delivery, the lack of essential drugs for cases management, public under-financing and severe reduction in populations purchasing power.

(iii) Problems related to drugs procurement and distribution

Problems related to drugs procurement and distribution can be examined under two aspects:

- The low availability of drugs in all public health facilities
- The structural problems of the pharmaceutical sub-sector.

a- The low availability of drugs

Stocks out in public health care and procurement facilities are frequent and often of long duration.

In the private sector, despite current improvement, characterized by the timid introduction of essential generic drugs, the supply of branded pharmaceutical products remains the main alternative for populations.

The main causes of drugs shortages in public health facilities are due to several factors, including:

- a weak financial capacity of health care facilities deriving from the under-financing of the public sector, of the low purchasing powere of populations and of the weakness of solidarity and disease risk sharing mechanisms.
- the weak performance of the upstream procurement system
- The irational utilization of available drugs at the healthcare facility level
- the incorrect assessment of pharmaceutical products needs at all levels.

b- The structural problems of the pharmaceutical sub-sector.

[17] Health Statistics Yearbook 2006

The main structural obstacles that hinder the performance of the pharmaceutical sub-sector are:

- The incoherent scattering of drug procurement pipelines leading to lost of volume effect on order purchase prices, on holding and distribution costs. The main determinants of this situation are the lack of coordination of international aid in the pharmaceutical sub-sector and the lack of national purchase bulking at the level of the PCG.
- the weak capacity of the national procurement facility (PCG) because of its under-capitalization (insufficient working capital), the major depreciation of national currency which affects its treasury and difficulties in procuring currencies needed for import of pharmaceutical products – considering that there is no local production of drugs.
- the expansion of the drugs illegal market which constitutes a real danger for public health and a destabilization factor of the formal drug management system.
- the high prevalence of poverty in the population in almost all the regions and the dilapidation of the macro economic framework of the country
- the high cost of drugs in the private sector
- the low level of social coverage (less than 5%)
- the inapropriate price structure
- the lack of incentives to sell generic drugs
- the absence of price control
- The lack of enforcement of the regulation on social drugs
- the lack of exemption on medical devices and reagents (27.01% of customs fees and taxes)[18].

(iv) Inadequate Distribution and Demotivation of Human Resources

The number of health personnels is low relative to the minimum staffing needs defined at each tier in the health map. This staffing shortage is particularly acute for midwives and orderlies, categories whose presence would contribute a lot to care improvement. Some categories, like pharmacy and radiology technicians, are threatened by extinction.

In addition, the personnel is not well distributed and is concentrated in urban areas with important regional disparities. This is particularly pronounced at the level of the capital, which comprises 15% of the population but about 50% of physicians and midwives and 38% of orderlies. There are 17 districts most affected by staff shortage: Dubreka, Forecariah, Boke, Boffa, Télimele, Koubia, Lélouma, Tougue, Mali, Dinguiraye, Pita, Dalaba, Kouroussa, Kerouane, Mandiana, Macenta et Yomou. The fact that health personnel availability does not overlap with poverty distribution map is notable. However, out of these 17 districts, 11 belong to poverty zones as defined by the Ministry of planning. These imbalances constitute a limiting factor to immunization activities and to healthcare system performance improvement[19].

[18] Study on secure drugs purchase funds
[19] Assessment of the health component of PRS

There is no policy of health human resources development. Indeed, a lack of recruitment plan, redistribution, career plan, continuing education and improvement of living standards of personnel are observed.

The inadequacy between initial training and health system needs[20] is obvious because of the insufficient coordination between the various sectors involved in training and utilization of health personnel. This is compounded by the difficulties in recruiting new agents because of economic difficulties. This causes an excess of certain categories on the job market (physicians and THA, etc.) and a shortage or a lack of other specialties (dentists, midwives, health engineers and technicians, specialist physicians, etc.)

The shortcomings (numerical and qualitative), the inadequate distribution, the initial training inadequacy and the low level of human resources motivation evoked above weaken the availability, quality and continuity of all fields interventions.

(v) Weak coordination of health interventions

Despite, the updating of the Ministry of health organigram to corrct organizational deficiencies observed during the sector analysis performed for the NHDP, the institutional position of projects and transversal programs always remain uncertain. Similarly, certains tasks and responsibilities remain to be clarified at the level of the central administration.

In the area of system management, a weak technical, managerial and logistical capacity at all tiers of the health pyramid is still noted. Coordination, planning and monitoring and evaluation functions are not well mastered. Support from central level to deconcentrated facilities in developping tools and techniques of planning, monitoring and evaluation, remains insufficient.

The performance of the health information system remains weak. The NSHI audit performed in 2008 by the MSHP, underscore the inefficiency of the existing information system. Analyses showed that this low performance is related to:

- the weak coordination between the health information system operations;
- the inadequacy of the work ing environment of services in charge of health statistics at all tiers of the health pyramid;
- the qualitative and quantitative shortage of personnel in charge of collecting and managing health statistics;
- the low computerization level of the system: computer equipment, software, internet not available, etc.) ;
- the lack of adequate equipment and work material: supervision and training logistics, stocks out of collection supports,

The completeness of report transmission has been maintained to 100% since 2004 but there are timeliness problems due in part to insufficient competent human resources in rural areas, a low involvement of the private sector and a weak capability of analysis of surveillance data at all levels of the system. Some of these deficiencies are been remedied to through the implementation of GAVI/Immunization funding.

In the context of the decentralization, the Government has defined a code of collectivities which transfers to urban and rural development communities the responsibility of the

[20] Ressources humaines en santé en Guinée (Alain Le Vigouroux)

management of health services and sanitation, thus facilitating the participation of users to the management of their facilities.

(vi) under-financing of the sector

Financing issues od the system can be examined under the following dimensions: cost recovery, financing by local communities, state financing and financing by development partners.

A uniform costs recovery system is implemented in all regions of the country. Funds generated by this approach, and re-infused in health services financing, contribute to cover some expenditures like drugs, fuel for cold chain and advanced strategies and management tools. However, this system showed its limits. In practice, it does not take into account regional economic disparities.

Moreover, over-charge has been instituted, market costs have increased significantly while the population is becoming poorer and poorer (53.2% of the population lives below the poverty threshold).

The weak development of mechanisms of disease risk sharing in the country constitutes a limit to alternate financing of the sector and to the control of poverty and exclusion.

The share of the Sate budget allocated to the Ministry of health is small as shown in the following tables.

Evolution of the budget allocated to MSHP relative to the national budget from 2004 to 2007

Year	2004	2005	2006	2007	Total
State	1,338,557,791	1,722,546,247	2,951,361,568	3,518,752,956	9,531,218,562
Min. Health	41,001,692	56,996,352	72,786,415	89,997,186	260,781,645
%	3.06%	3.31%	2.47%	2.56%	2.74%

Source: Chain of expenditures, Ministry of Economy, Finance and Planning (2008)

Evolution of the MSHP budget execution relative to the execution of the national budget from 2004 to 2007

Year	2004	2005	2006	2007	Total
State	1,371,787,875	1,881,617,830	2,395,849,981	2,229,983,011	7,879,238,697
Min. Health	26,163,910	43,231,950	50,277,597	60,099,785	179,773,242
%	1,91%	2,30%	2,10%	2,70%	2,28%

Source: Chain of expenditures, Ministry of Economy, Finance and Planning (2008)

As shown in the table above, the expenditures of the Ministry of health are about 2% of the total expenditures of the State.

Moreover, according to the rapid assessment of health districts operationality, the State contribution to fiancing of health services in districts is not equitable. For instance, when Koubia benefits from 154,598,531 GNF, Ratoma receives 1,485,364,870 GNF corresponding, respectively, to 1.276 GNF and 3.464 GNF per capita and per year, or to a 1 to 3 ratio[21].

This situation hinders essential health services provision including immunization.

It appears that the health system financing is nowadays deficient and the Government faces many difficulties to mobilize additional resources needed to sustain the gains and improve the

[21] Rapid assessment of health district operationality

health system performance, in particular for purchase of vaccines, equipment and cold chain material.

Because of the low internal resources mobilization, financing for investments and operating expenses in the sector is largely dependent on external contributions.

The districts do not know well the level of external financing they receive because its management is sometimes done directly by partners or the Ministry. Available data on interventions distribution indicate that the coordination of stakeholders financing and fiancial integration remains weak. Moreover, each partner uses a specific process. Managers are therefore confronted to many different procedures, making funds disbursement difficult. In fact, some partners that were coveting the entire country concentrate their cooperation to few health districts.

In health districts, the constraints due to the lack of control of the fiancial flow stem from the fact that sometimes it is the partner or the national program which implement field activities such that the management team is not aware of the total sums spent for some activities.

The two largest common expenditure items in districts are personnel costs (69.6%) and essential drugs procurement (15.3%). Expenditures for the solidarity funds were only 0.52%. Investment expenditures are not well known as is public aid to development.

Funds for the indigent put in place by the government cannot target and take efficient care of vulnerable people in reference facilities.

To the applicant: section 3.3

- *Please provide information on those barriers that are being adequately addressed with existing resources (Table 3.3). These could be socio economic, political or related to gender analysis based on social science research.*

3.3: Barriers that are being adequately addressed with existing resources

The Ministry of Health and Public Hygiene, in collaboration with partners, makes some efforts to improve essential care provision to the population. These are essentially:

A. State:

- PIP-TCP: The tri-annual investment plan includes he construction of health centers and posts in the "investment" component of the EPI/PHC.
- The purchase of motorcycles, radiocommunications, vaccines and preservation material.
- the advocay toward partners to make C-seection free of charge in all public health facilities by providing technical equipment (C-section boxes and drugs kits), personnel training and review of the care standards and procedures.

B. Partners:

- **World Bank: (SNHDP)**

In the "Health Services Strengthening" component of this project, efforts were undertaken to:

- **Improve infrastructures**: by supporing 200 health posts, 198 health centers and 18 district hospitals.
- **Improve CPC utilization:** investments are in process to improve treatment of diarrhea and control of ARI, malaria and malnutrition
- **Improve preventive services coverage:** investments are realized for the services package that covers antenatal care, normal and emergency delivery and IMCI.
- **Support of MURIGAs** for a risks sharing system. The project supports the MURIGA system, which has demonstrated its usefulness. It focuses essentially on disease risk sharing to improve the health of pregnant women. The districts covered by this intervention are: Beyla, Dalaba, Dabola, Dinguiraye, Gaoual, Gueckedou, Kerouane, Kissidougou, Koubia, Koundara, Kouroussa, Lelouma, Mali, Mandiana, Pita, Telimele, Tougue et Siguiri.

  Finally, the support includes providing CEOC equipment to the 18 hospital in the project intervention area and BEOC material to the 198 health centers, the delivery of supervision vehicles and motorcycles for advanced strategies. This project provides a subsidy for fuel and consummables purchase to DHDs and health centers.
- **Quality of care improvement:** investments are realized to strengthen the chain of care, to improve the RH standards and to increase FP utilization.

- **UNFPA**

The 6th Guinea-UNFPA Cooperation Program (2007-2011) supports: (1) the implemantation of quality reproductive health services for all social groups, in particular young people and women, in poverty zones and zones coming out of crisis, (2) the promotion of an environment in which sexually active individuals adopt a less risky behavior, giving priority to adolescents, young people and women, (3) addressing questions relative to population, women issues and

RH in programs and policies at all levels and (4) the promotion of women and girls rights, gender equality and equity between men and women.

More specifically, it is about improving access to maternal health and to services addressing needs of young people in the intervention zone by improving the quality of HR integrated care and services (FP, antenatal and post-natal services, EONC, PAC, fistulae and STI/HIV/AIDS).

This component is implemented jointly with other partners for the reduction of maternal and neonatal mortality in the districts of: Boke, Lelouma, Pita, Telimele, Mali and Tougue for quality BEOC, CEOC and PAC services in health facilities of the intervention zone and the extension of MURIGAs.

- **WHO**

Interventions of WHO are included in the cooperation strategy document 2008-2013. These are essentially:

- ✓ **Support to the Organization of the Health System**

The priority of the Health Department is to improve the sector performance through strengthening health coverage at primary, secondary and tertiary levels to guarantee an equitable access to a better quality care and essential health services package.

- ✓ **Support o the Development of human resources**

WHO provides support to the update of the human resources development plan through strengthening national competencies at the level of initial training as well as continuing education, and supporting national training institutions and also the human resource management initiative in the sector.

- ✓ **Support to the management and utilization of health information and to research development**

WHO brings its support to the development of a health information and research system that will facilitate the decision taking process at all tiers of the health pyramid.

- ✓ **Prevention, eradication and control/surveillance of transmittable diseases**

WHO provides its technical support in resources mobilization and implementation of strategies for:

- strengthening immunization activities through the implementation of the EDA strategy and specific campains;
- strengthening leprosy, dracunculosis, poliomyelitis and maternal and neonatal tetanus eradication activities;
- providing drugs to programs (leprosy, tuberculosis, human african trypanosomiasis and onchocercosis);
- strengthening capabilities of laboratory involved in integrated disease surveillance (meningitis, cholera, yellow fever and measles);
- strengthening national capacity in preparedness, surveillance and response against avian flu.
- developping and implementing the 2008-2012 strategic plan of control of neglected tropical diseases;

- strengthening epidemiological surveillance of blindness and the management of cases of diseases causing blindness.

✓ **Women, child and adolescent helath**

The interventions focus particularly on:

- scaling-up the integrated management of childhood illnesses (IMCI) strategy;
- validating and implementing the adolescent and young people health and development strategic plan;
- implementing the road map for accelerating the reduction of maternal, neonatal and infant-juvenile mortality.
- developing and implementing the national health policy of aged people.

✓ **Preparedness to emergency situations and relief organization**

WHO provides its support for:

- advocacy toward necessary resources mobilization
- implementation of the national action plan for preparedness and response to emergency situations, epidemics and disasters.

o **UNICEF**

UNICEF interventions in the health domain focus on the Child Survival and Development program which includes 4 projects:

1- **EPI:** UNICEF brings its support to immunization services on the entire national territory. This support targets strengthening of routine immunization activities, national immunization campains, surveillance of EPI target diseses and the formulation by the MSHP of the short and mid term policy and strategies.

2- **Access to quality maternal and child care:** scaling-up of the ACSDS strategy in 10 districts (Kindia, Forecariah, Dabola, Kissidougou, Dinguiraye, Faranah, Gaoual, Koundara, Mali et Tougue); targets the improvement of utilization of curative care for children under 5, the IPT, the increase of assisted deliveries and finally the health support in emergency and epidemics zones.

3- N**utrition**: distribution of vitamine A and deworming drugs to children under 5 and to women after delivery, management of chlidren malnutrition cases, improvement of iodized salt consumption and distribution of impregnated bed nets.

4- **PMTCT:**

- Counseling and testing at the national level,
- Extension of PMTCT coverage,
- Treatment of children with AIDS.

o **GTZ**

The German technical cooperation supports the Ministry of Health in health quality improvement to increase services utilization and reduce the morbidity burden in Mid- and Upper Guinea.

The instrument used for the assessment is the Quality Competition, which combines an auto-assessment, a review of auto-assessment guides and a facilities audit.

On the basis of tools developped, the performance of health facilities is assessed and continuous improvement measures are proposed under the form of an improvement plan.

- **Global Funds to Fight HIV/AIDS, Tuberculosis and Malaria.**

Current interventions of the Global Funds to Fight HIV/AIDS, Tuberculosis and Malaria contribute to improving mother and child health through:

- intermittent preventive treatment of pregnant women,
- distribution of impregnated bed nets, management of simple malaria cases in health facilities,
- management of AIDS patients with ARVs,
- HIV/AIDS prevention activities: sensitization, blood transfusion safety and PMTCT.
- screening and treatment of TB cases, in collaboration with other partners, in all the HC.

To the applicant: section 3.4

- *Section 3.4 should outline the most important barriers not being adequately addressed and give reasons why they have been prioritized in terms of those that are not currently funded by other sources, such as those that will have maximum impact or catalyse other activities or for geographic or social reasons. If there is an obvious lack of a national policy that emphasises a human rights based approach to accessing health care (including gender or lack of competencies at different levels of the health system then it should be mentioned here.*

3.4: Barriers not being adequately addressed (in order of highest priority)

Despite the efforts of the Government and its partners, some barriers persist and deserve GAVI intervention to improve performances of immunization services. These barriers are related to: (i) the low coverage in health facilities and equipment, (ii) the weak human resources management capacity, (iii) the low availability of quality essential drugs and (iv) the weak coordination and management of the sector.

Coverage in facilities and equipment

The health coverage remains very limited and the quality of care is low because of the low availability of some specialized equipment. These problems are particularly acute in certain regions of the country which do not benefit froma substantial external support. GAVI support would allow to augment the health coverage by building, renovating and equipping health centers and strengthening the technical expertise of reference hospitals in these zones.

Human Resources

The unequal distribution of personnel and the lack of qualified personnel in facilities accross the country causes the non-availability of several services in some zones. Immunization services do not operate regularly because of personnel instability due to the lack of personnel motivation and retention policy. GAVI support will allow strengthening personnel management to ensure continuity in service operation, particularly immunization services.

Procurement of quality essential drugs

The low, internal as well as external, resources mobilization limit the quantity of drugs available in health facilities. GAVI intervention will allow strengthening stocks of drugs essential to manage diseases of mothers and children. This drug availability will promote the utilization of health centers and allow a better monitoring of women and children.

Coordination of interventions

The weakness of mechanisms of coordination of interventions at the different tiers af the health pyramid is at the basis of the existence of multiple management tools and the low level of activities integration mostly at the district level. Local managers have difficulties in controling the numerous vertical programs because of their direct intervention in the field. GAVI support will allow strengthening technical support and interventions coordination (planning, monitoring and evaluation, supervision and organization) at all levels.

To the applicant: section 3.5

- *Section 3.5. should outline the barriers to civil society and the private sector in delivering immunization services and strengthening health systems and becoming part of the national process to increase immunisation coverage*

3.5: Describe specific barriers to civil society and the private sector in delivering immunization services and strengthening health systems or becoming part of the national process to increase immunisation coverage

Political and economical options are favorable to the development of the private sector.

At the geographical level, about 555 of private facilities, all categories included, are located in the capital, Conakry.

The activities package that has been developped remains dominated by curative care, deliveries and much less preventive care such as ANC at the level of healthcare offices and children monitoring at the level of midwives offices.

Private sector operators are very little interested by rural areas and by activities that are not lucrative. The collaboration between private and public sector is very weak.

To remove these barriers, a contrcat policy has been elaborated to facilitate the extension of immunization services to private facilities and to civil society organizations. As such, the code of decentralized collectivities provides large responsibilities to local elected officials in the activities of sensitization and the management of health centers.

Moreover, in the implementation of primary health care, a management committee derived from the population, support community participation by activities of sensitization and support to the management of health centers. However, the operation of these committees remain confronted to members demotivation due to the lack of reward system and adequate working resources compromising the immunization coverage mostly in rural areas.

Section 4: Goals and Objectives of GAVI HSS Support

To the applicant: sections 4.1 and 4.2

- *Please describe the goals of GAVI HSS support below (Table 4.1).*
- *Please describe (and number) the objectives of GAVI HSS support (Table 4.2). Please ensure that the chosen objectives are SMART (specific, measurable, achievable, realistic and time-bound).*
- *This section should demonstrate a) why the proposed HSS objective is expected to sustain immunization coverage and b) how the proposed activities will ensure the achievement of HSS objectives. It is therefore very important to show the links between identified barriers - goals - objectives - activities and indicators. They should follow a logical sequence and distinct outputs, outcomes and processes should be identified.. It should then be evident how the proposed activities will increase or sustain immunization coverage*
- *Geographic issues: If a discrete sub national area has been selected for intervention, it should be clear how and why the area(s) were selected and the rationale for the geographic specific indicators and criteria.*
- *Any supporting documents or background documents (such as the Human Resource Policy Document Number…., procurement policy Document Number…. or Mid Term Expenditure Framework Document Number….) should be quoted here and references should be precise in terms of sections and page numbers referred to in the application.*

4.1 : Goals of GAVI HSS Support

The Health System Strengthening proposal (HSS) of the Republic of Guinea which is the subject of this document is in line with the realization of the NHDP by increasing the supply and the utilization of quality health services including immunization ones.

It proposes to therefore contribute to the realization of this goal that the MSHP has defined in the NHDP: to contribute to improving the state of health of Guinean populations, in particular the most vulnerable social strata.

4.2 : SMART objectives of GAVI HSS Support

Two objectives have been defined to remove the barriers, on one hand, to essential care accessibility in 5 districts with low immunization coverage and, on the other, to health system management. These objectives are:

- To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage
- To strengthen management capacity in 5 health districts, 2 regional health directorate and at the central level by the end of 2011.

These objectives integrate in the implementation of the following strategic axes of the NHDP:

- Integrated control of maternal morbidity and mortality (Strategic axis nº 1)
- Strengthening of institutional and management capacities (Strategic axis nº 2)

To reach these objectives, the targeted intervention areas are:

- Immunization, reproductive health and curative care for the first objective of

increasing access to essential care for the integrated control of maternal morbidity and mortality in the 5 health districts (Strategic axis nº 1 of the NHDP).

- Operational research, monitoring and evaluation system and coordination/ management for strengthening institutional and management capacity at different tiers of the health pyramid (Strategic axis nº 1 of the NHDP).

1. **Improving access to essential care for the integrated control of maternal morbidity and mortality in the 5 health districts (Strategic axis nº 1 of the NHDP).**
   - Improving geographical accessibility to prevention interventions by organizing advanced strategies, providing motorcycles to HC of the 5 targeted districts, providing solar refrigerators and BEOC materials, providing equipment and procuring essential drugs and specific inputs to health facilities, involving private facilities of the civil society and sensitizing communities,
   - Mobilizing health human resources toward health facilities in rural areas by motivating and retaining personnel,
   - Training human resources, while employed in health districts, in RH, child health, curative care and management.
   - Strengthening obstetrical referral and quality of patient management by providing ambulances to Dubreka and Fria hospitals, providing technical equipment, drugs and consumables and training and supervising personnel in the 5 districts.
   - Creating mutual insurance associations to improve financial accessibility for pregnant women, women in labor and children under 5.
2. **Strengthening institutional and management capacity in 5 health districts, 2 regional health directorates and at the central level (Strategic axis nº 2 of the NHDP).**

   This will be implemented through:
   - improving coordination by setting-up a multisectorial concertation framework and the meeting of the coordinating bodies of the sector (sub-district synthesis, RHTC and DHTC)[22],
   - strengthening capacity of regional and district managers in district health system management,
   - strengthening supervision activities and monitoring and evaluation mechanisms,
   - strengthening inter-sectorial colaboration and community participation,
   - performing studies on organization, human resources, information system and financing (mutual insurance associations),
   - technical assistance.

For a better efficiency, the proposal of health system strengthening with GAVI support, focuses on districts of maritime Guinea: Boke, Boffa, Coyah, Dubreka and Fria, selected according to the following criteria:

- complementarity with current interventions of external partners,
- concentration of GAVI support in a single geographic zone to avoid dilution of efforts.

[22] Mechanisms of coordination and monitoring of the health sector. MSHP, 2009

- potential for results in matter of essential services coverage (immunization and other health services),
- minimization of montoring charges.

Section 5: GAVI HSS Activities and Implementation Schedule

To the applicant: section 5.1

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

Note: Mechanisms for the technical and financial sustainability should be carefully outlined especially for GAVI support related to infrastructure, equipment, transport and human resources development efforts. This should include how these investments will be sustained after GAVI HSS support has finished. Reference should be made to the Infrastructure, Procurement or Human Resources Development strategies or policy documents (Document Number ....), if they exist.

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

- *For each SMART objective identified in Table 4.2, detail the major activities that will be undertaken to achieve that objective. Include the implementation schedule (duration, annual milestones, and end point if any) for each of these activities.*
- *Ensure timing of activity duration in table 5.2 is consistent with the timing of expenditures for each activity shown in table 5.3*

5.1: Sustainability of GAVI HSS support

The Government has undertaken measures that promote improvement of the sector financing and their pursuit and strengthening will allow the sustainability of GAVI supported interventions. The main actions are:

1. Promotion of the mutual insurance movement supported by the State with support of partners: GTZ, UNICEF, UNFPA, IDRC, DYNAM
2. Strengthening of decentralization by enacting the codes of collectivities, which transfer basic health services (health centers and posts) to collectivities allowing the mobilization of additional resources for health[23]
3. Debt forgiveness allowing the country to benefit from funds of the HIPC Initiative for health sector expenditures
4. Improving management and governance capacity allowing securization of budgetary lines for vaccine purchase, financing of consumables purchase to make free C-sections available,
5. The ministry of Heanth and Public Hygiene, in collaboration with its partners, is putting in place a mechanism of coordination of partners interventions in the sector to improve the efficiency of the external aid.
6. The exploitation of mining megaprojects in preparation will allow an increase of public resources which will contribute to health financing.
7. The gains from the support in terms of equipment, ingrastructures and personnel training will improve the quality of care and will lead to an increase of services utilization. These aspects will positively affect the perception of services by the population and will induce it to a greater contribution to the development of the health system.

[23] Code of Collectivities

To the applicant: section 5.2

- *Note: Please add (or delete) rows so that Table 5.2 contains the correct number of objectives for your GAVI HSS application, and the correct number of activities for each of your core objectives.*
- *Note: Please add (or delete) years so that Table 5.2 reflects duration of your GAVI HSS application*
- *Note: The budget for the first year should demonstrate the use of unit costs and a budget breakdown. This will add to the soundness and sense of realism of the proposal; especially for any activities that may include major training or procurement components. Budgets should be based on real costs and not based on contingency cost.*
- *For each objective identified in Table 4.2, please give details of the major activities that will be undertaken in order to achieve the stated objective and the implementation schedule for each of these activities over the duration of the GAVI HSS support.*

5.2: Major Activities and Implementation Schedule

Support area	Implementation period							
	Year 1 of implementation (2010)				Year 2 of implementation (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage								
SPD 1.1: IMMUNIZATION								
Activity 1.1.1: Provide 50 solar refrigerators to 50 HCs								
Activity 1.1.2: Grant performance bonuses to 150 agents of 50 HF in rural areas								
Activity 1.1.3: Support private facilities from civil society organizations to conduct sensitization activities and provide essential health services								
Activity 1.1.4: Provide 50 motorcycles to 50 HCs (25 motorcycles per year)								
Activity 1.1.5: Ensure proper operation and maintenance of 50 motorcycles								
Activity 1.1.6: Support the maintenance of 50 solar refrigerators								
Activity 1.1.7: Support civil society organization in developping health mutual insurance associations in the zone								
Activity 1.1.8: Organize sensitization through microprograms at 4 rural radio stations								
Activity 1.1.9: Support HC management committee in active research and sensitization activities								
Activity 1.1.10: Organize 12 sessions of community sensitization on MCH/FP activities per HC and per year								
SPD 1.2: Reproductive Health								
Activity 1.2.1: Organize 2 training workshops for 25 providers per session during 10 days in the RH field								

Support area	Implementation period							
	Year 1 of implementation (2010)				Year 2 of implementation (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 1.2.2: Allocate a start-up provision of pregnancy monitoring and delivery tools to 50 HC in the zone								
Activity 1.2.3: Provide 2 ambulances to 2 DH								
Activity 1.2.4: Ensure proper operation and maintenance of 2 ambulances in DH								
Activity 1.2.5: Provide 20 BEOC equipements to 20 HCs								
Activity 1.2.6: Provide 2 CEOC equipements to 2 DH								
Activity 1.2.7: Provide to 5 DH C-section kits for obstetrical emergencies								
SPD 1.3: Curative care								
Activity 1.3.1: Revise and adopt standardized treatment regimens (flowcharts and therapeutic protocols)								
Activity 1.3.2: Reproduce and disseminate standardized treatment regimens to 50 HC, 5 DHD, 5 DH and 2 RHD								
Activity 1.3.3: Organize 2 training sessions for 25 health agents per session during 10 days in IMCI, care rationalization and EDs management								
Activity 1.3.4: Allocate a start-up provision of drugs and medical consumables to 50 HCs								
Activity 1.3.5: Procure EDs and medical consumables to hospitals								
Objective 2.1: To strengthen management capacity in 5 health districts, 2 regions and at the central level by the end of 2011								
SPD 2.1: Operational Research								
Activity 2.1.1: Conduct a study on the organizational structure of public health facilities								
Activity 2.1.2: Conduct a study on the feasibility of the implementation of mutual insurance associations in the zone								
Activity 2.1.3: Assess the implementation of the 2007-2011 cMYP and re-program the 2012-2016 cMYP								
Activity 2.1.4: Assess the implementation of the 2007-2011 NHDP and re-program the 2012-2017 NHDP								
SPD 2.2: Monitoring and Evaluation System								

Support area	Implementation period							
	Year 1 of implementation (2010)				Year 2 of implementation (2011)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 2.2.1: Organize biannual supervision visits from the central level to the intermediary and peripheral levels								
Activity 2.2.2: Organize quarterly supervision visits from the regional level to the HDs of the targeted zone								
Activity 2.2.3: Organize supervision visits every two months from the District to the hospital and the HCs of the targeted zone								
Activity 2.2.4: Provide information system and management tools								
Activity 2.2.5: Produce quarterly statistical bulletins								
Activity 2.2.6: Provide 5 supervision vehicles (4x4 Pick-up) to 5 health districts								
Activity 2.2.7: Ensure proper operation and maintenance of the 5 supervision vehicles of the 5 DHD								
SPD 2.3: Coordination/management								
Activity 2.3.1: Support HSCC meetings logistics								
Activity 2.3.2: Support the organization of 2 RHTC in the targeted zone								
Activity 2.3.3: Support the organization of 10 DHTC in the targeted zone								
Activity 2.3.4: Develop a manual of implementation of mutual insurance associations								
Activity 2.3.5: Organize 2 multisectorial concertation meetings per year at the central level and in the targeted zone								
Activity 2.3.6: Support the development of district health development plans (DHDP) in the targeted zone								
Activity 2.3.7: Perform an annual audit of the accounts of the project								
Activity 2.3.8: Organize a 4 days workshop to develop the documents of creation and operation of a multisectorial concertation framework at the different levels								
Activity 2.3.9: Organize a training session for regional and districts managers in management of district health systems during 10 days								

Brief comments on main activities included in this proposal.

The activities are presented by domains of intervention and by expected results.

Objective 1: To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage

To reach this objectives, 3 services provision domains are planned: (1) access to immunization services, (2) access to reproductive health services, (3) access to curative care services.

❖ **For the immunization domain (SPD 1):**

The aim is to improve the availability of motorcycles to organize advanced strategies and solar lighting kits and refrigerators, to motivate health personnel working in rural areas, to involve civil society organizations in the broadening of health coverage and the development of mutual insurance associations as well as the revitalization of community participation.

More specifically, it will include:

- ✓ providing 50 motorcycles and 50 refrigerators to health centers to develop essential care including immunization in remote areas;
- ✓ contracting community, for-profit and faith-based private sector present in the health regions to broaden access to prevention services including immunization;
- ✓ mobilizing and retaining health personnel in rural areas by paying bonuses to health personnel working in the 5 health districts;
- ✓ helping health centers management committees to stimulate demand for care through informtaion and involving them in active research and decision-making for the management of health facilities;
- ✓ supporting the development of mutual insurance associations to minimize the financial barriers through collaboration with civil society organizations specialized in this domain;

❖ **For the reproductive health domain (SPD 2):**

Interventions will aim to stimulate the demand for care at the level of the target population and to improve the quality of patient management in care facilities and the referral system. In addition to interventions included in the SPD 1, it will more specifically include:

- ✓ Providing with basic emergency obstetrical care (BEOC) equipment to 20 health centers and consumables kits for C-sections to 5 hospitals.
- ✓ Providing ambulances to 2 hospital and cover expenses for their operation and maintenance to facilitate timely referral of complicated obstetrical cases from the periphery to the hospital and improve the quality of patient management by providing comprehensive emergency obstetrical care (CEOC) equipment;
- ✓ Training and/or re-training personnel on subjects relating to maternal mortality reduction for 50 health agents during about 10 days.

❖ **For the curative care domain (SPD 3):**

Efforts will be made to make drugs available in all facilities, to rationalize prescriptions and strengthen skills of integrated management of childhood illnesses. It will include in particular:

- ✓ Allocating a start-up provision of essential and generic drugs and consummables for a 6 months consumption to 50 HCs and 5 HP. These drugs will be part of the minimum package of activities, which will be sold in facilities, and the income from these sales will be used as a revolving fund for replenishment. The responsibility of the health centers management committees in the management of drugs and incomes generated by the sale of these services and the strengthening of supervision in health care facilities will constitute a guaranty of sustainability.

  The country is going through an unprecedented financial and economic crisis due to endogenous and exogenous factors that drastically limit the ability of the State in term of health financing in general and drugs financing in particular.

  The inclusion of the drug component of this proposal will allow reducing the drug stocks out, and improving the credibility of care facilities and the quality of patient management.

- ✓ Revising, adopting and disseminating flowcharts and standardized treatment protocols for a rational utilization and management of drugs
- ✓ Training 50 health agents during 10 days on IMCI.

Objective 2: To strengthen management capacity in 5 health districts, 2 regional health directorate and at the central level by the end of 2011

To reach this objective, activities of planning, coordination, monitoring and evaluation, supervision, management ans operational research will be strengthened at the central level and the deconcentrate level of the targeted zone to improve governance and operational and technical efficiency of management structures at all levels.

More specifically, it will include:

❖ **Operational Research (SPD 1):**

The following will be conducted:

- ✓ operational research on the organizational structure of public health facilities,
- ✓ operational research on the feasibility of the implementation of mutual insurance associations in the intervention zone,
- ✓ assessment of the NHDP implementation,
- ✓ assessment and re-programming of the cMYP.

❖ **Monitoring and evaluation system (SPD 2):**

- ✓ provide supervision and monitoring means to central and district management structures: the 5 districts will reveive all-terrain vehicles for supervision. Supervision visits will be performed by the health system Coordinating Committee, the managing teams of RHD and DHD to improve the performance of personnel in regions, districts and health centers. The central level will also conduct regular supervision visits at the regional level and if needed in health districts, using a vehicle contributed by other partners (SNHPD);
- ✓ Support the national information and health management system by the provision of data collection tools to the facilities and the regular production of quarterly bulletins.

❖ **Coordination/Management (SPD 3)**

- ✓ Support the coordination and intra- and inter-sectorial concertation bodies: meetings of HSCC, RHTC and DHTC and other multisectorial coordinating bodies will benefit from technical and fiancial support to qualify them for a better performance of the health system;
- ✓ stengthen management skills of health districts: Districts will be strengthened by training to allow them to fully assume their support mission to the health centers and the hospitals. the capacity of management bodies like the health centers management committees and of community participation bodies will be strebgthened for a better control of the management of various available resources;
- ✓ improve the planning and strategic decision making framework at the district level: health districts will develop district health development plans, which will will be detailed in annual plans with comprehensive sectorial budget. The DHDP will be approved by the Ministry of health before their implementation. GAVI financing will be complementary to other financing available or expected in the implementation of these district plans;
- ✓ mobilize technical assistance to support the realization of studies planned in the proposal and of audits for proper accounting.

5.3: Costed implementation plan for the first year of implementation

To the applicant: section 5.3

Note: The first year's implementation plan should be outlined in section 5.3, giving details of timelines, inputs, outputs and processes to be monitored, with details of costs (and unit costs at least for the first year implementation).

Costs per Objective and per SPD of Year 1 of HSS Support to the Republic of GuineaCalcul Coûts Soutien GAVI-RSS VF.xls

Support area	Units	Unit Cost	Quantity					Cost (in USD)				
			T1	T2	T3	T4	Total	T1	T2	T3	T4	Total
Objective 1: To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage												
SPD 1.1: IMMUNIZATION												
Activity 1.1.1: Provide 50 solar refrigerators to 50 HCs	kit	6 000			50		50			300,000		300,000
Activity 1.1.2: Grant performance bonuses to 150 agents of 50 HF in rural areas	h/year	120	150	150	150	150	600	18 000	18 000	18 000	18 000	72 000
Activity 1.1.3: Support private facilities from civil society organizations to conduct sensitization activities and provide essential health services	facility/year	1 000	5				5	5 000				5 000
Activity 1.1.4: Provide 50 motorcycles to 50 HC	each	3 300			25		25			82 500		82 500
Activity 1.1.5: Ensure proper operation and maintenance of 50 motorcycles	moto/quart.	70	50	50	50	50	200	3 500	3 500	3 500	3 500	14 000
Activity 1.1.6: Support the maintenance of 50 solar refrigerators	fridge/quart.	50	50	50	50	50	200	2 500	2 500	2 500	2 500	10,000
Activity 1.1.7: Support civil society organization in developping mutual insurance associations in the zone	organ.	10,000	2				2	20,000				20,000
Activity 1.1.8: Organize sensitization through microprograms at 4 rural radio stations	program	20	26	26	26	26	104	520	520	520	520	2 080
Activity 1.1.9: Support HC management committee in active research and sensitization activities	man. com.	90	50				50	4 500				4 500
Activity 1.1.10: Organize 12 sessions of community sensitization on MCH/FP activities per HC and per year	session	10	150	150	150	150	600	1 500	1 500	1 500	1 500	6 000
SPD 1.1 Sub-Total								55 520	26 020	408 520	26 020	516 080

Support area	Units	Unit Cost	Quantity					Cost (in USD)				
			T1	T2	T3	T4	Total	T1	T2	T3	T4	Total
SPD 1.2: Reproductive Health												
Activity 1.2.1: Organize 2 training workshops for 25 providers per session during 10 days in the RH field	h/d	63				250	250				15 750	15 750
Activity 1.2.2: Allocate a start-up provision of pregnancy monitoring and delivery tools to 50 HC in the zone	kit	200	50				50	10,000				10,000
Activity 1.2.3: Provide 2 ambulances to 2 DH	ambulance	40,000			2		2			80,000		80,000
Activity 1.2.4: Ensure proper operation and maintenance of 2 ambulances in DH	veh./quart.	1 812	2	2	2	2	2	3 624	3 624	3 624	3 624	14 496
Activity 1.2.5: Provide 20 BEOC equipements to 20 HCs	kit	10,000			20		20			200,000		200,000
Activity 1.2.6: Provide 2 CEOC equipements to 2 DH	kit	30,000			2		2			60,000		60,000
Activity 1.2.7: Provide to 5 DH C-section kits for obstetrical emergencies	kit	60		1 403			1 403		84 180			84 180
SPD 1.2 Sub-Total								13 624	87 804	343 624	19 374	464 426
SPD 1.3: Curative care												
Activity 1.3.1: Revise and adopt standardized treatment regimens (flowcharts and therapeutic protocols)	workshop	7 000	1				1	7 000				7 000
Activity 1.3.2: Reproduce and disseminate standardized treatment regimens to 50 HC, 5 DHD, 5 DH and 2 RHD	copy	25	70				70	1 750				1 750
Activity 1.3.3: Organize 2 training sessions for 25 health agents per session during 10 days in IMCI, care rationalization and EDs management	h/d	63				500	500				31 500	31 500
Activity 1.3.4: Allocate a start-up provision of drugs and medical consumables to 50 HCs	kit	5 000			50		50			250,000		250,000
Activity 1.3.5: Procure EDs and medical consumables to hospitals	kit	15 000			5		5			75 000		75 000
SPD 1.3 Sub-Total								8 750	0	325 000	31 500	365 250
Objective 1 Total:								77 894	113 824	1 077 144	76 894	1 345 756

Support area	Units	Unit Cost	Quantity					Cost (in USD)				
			T1	T2	T3	T4	Total	T1	T2	T3	T4	Total
Objective 2: To strengthen management capacity in 5 health districts, 2 regional health directorate and at the central level by the end of 2011												
SPD 2.1: Operational Research												
Activity 2.1.1: Conduct a study on organizational structure of public health facilities	study	10,000	1				1	10,000				10,000
Activity 2.1.2: Conduct a study on the feasibility of the implementation of mutual insurance associations in the zone	study	10,000		1			1		10,000			10,000
Activity 2.1.3: Assess the implementation of the 2007-2011 cMYP and re-program the 2012-2016 cMYP	study	14 000					0					0
Activity 2.1.4: Assess the implementation of the 2007-2011 NHDP and re-program the 2012-2017 NHDP	study	18 572					0					0
SPD 2.1 Sub-Total								10,000	10,000	0	0	20,000
SPD 2.2: Monitoring and Evaluation System												
Activity 2.2.1: Organize biannual supervision visits from the central level to the intermediary and peripheral levels	visit	2 000		1		1	2		2 000		2 000	4 000
Activity 2.2.2: Organize quarterly supervision visits from the regional level to the HDs of the targeted zone	visit	1 200	2	2	2	2	8	2 400	2 400	2 400	2 400	9 600
Activity 2.2.3: Organize supervision visits every two months from the District to the hospital and the HCs of the targeted zone	visit	600	7	8	7	8	30	4 200	4 800	4 200	4 800	18 000
Activity 2.2.3: Provide information system and management tools	kit	20	70				70	1 400				1 400
Activity 2.2.4: Produce quarterly statistical bulletins	release	2 000	1	1	1	1	4	2 000	2 000	2 000	2 000	8 000
Activity 2.2.5: Provide 5 supervision vehicles (4x4 Pick-up) to 5 health districts	vehicle	25 000		5			5		125 000			125 000
Activity 2.2.6: Ensure proper operation and maintenance of the 5 supervision vehicles of the 5 DHD	veh./quart.	1 812	5	5	5	5	20	9 060	9 060	9 060	9 060	36 240
SPD 2.2 Sub-Total								19 060	145 260	17 660	20 260	202 240

Support area	Units	Unit Cost	Quantity					Cost (in USD)				
			T1	T2	T3	T4	Total	T1	T2	T3	T4	Total
SPD 2.3: Coordination/management												
Activity 2.3.1: Support HSCC meetings logistics	meeting	200	1	1	1	1	4	200	200	200	200	800
Activity 2.3.2: Support the organization of 2 RHTC in the targeted zone	session	2 000	1	0	1	0	2	2 000		2 000		4 000
Activity 2.3.3: Support the organization of 10 DHTC in the targeted zone	session	1 000		5		5	10		5 000		5 000	10,000
Activity 2.3.4: Develop a manual of implementation of mutual insurance associations	document	5 258			1		1			5 258		5 258
Activity 2.3.5: Organize 2 multisectorial concertation meetings per year at the central level and in the targeted zone	meeting	500	8		8		16	4 000		4 000		8 000
Activity 2.3.6: Support the development of district health development plans (DHDP) in the targeted zone	study	3 000		5			5		15 000			15 000
Activity 2.3.7: Perform an annual audit of the accounts of the project	study	7 000				1	1				7 000	7 000
Activity 2.3.8: Organize a 4 days workshop to develop the documents of creation and operation of a multisectorial concertation framework at the different levels	workshop	7 000	1				1	7 000				7 000
Activity 2.3.9: Organize a training session for regional and districts managers in management of district health systems during 10 days	workshop	7 260			1		1			7 260		7 260
SPD 2.3 Sub-Total								13 200	20 200	18 718	12 200	64 318
Objective 2 Total:								42 260	175 460	36 378	32 460	286 558
GRAND TOTAL								120 154	289 284	1 113 522	109 354	1 632 314

Section 6: Monitoring, Evaluation and Operational Research

To the applicant: sections 6.1, 6.2 and 6.3

Note: It is strongly recommended that the chosen indicators are linked with proposal objectives and not necessarily with activities. Where possible, sex disaggregated and age specific data should be used and made available. Where possible, sex disaggregated and age specific data should be used and made available.

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

Note: The chosen indicators should be drawn from those used for monitoring the National Health Sector Plan (or equivalent) or cMYP and ideally be measured already (i.e. not a new indicator identified specifically for the GAVI HSS support). Examples of additional impact and outcome indicators are given in the tables below. It is recommended that when activities are implemented primarily at sub-national level that indicators are monitored, to the extent possible, at sub-nationally as well.

- *All the presented data in this application form should be consistent with other GAVI proposals and reports and with other official health reports and documents. Any discrepancies between these data and those presented in this proposal or the GAVI Annual Progress Reports should be fully explained and justified. This is especially important for the birth cohort, target populations and coverage rates.*

- *All applications should identify a nominated focal point in Government service who oversees the monitoring and evaluation of the GAVI HSS proposal*

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

i) National DTP3 coverage rate (%)
ii) Number / % of districts achieving ≥ 80% DTP3 coverage [24]
iii) Under five mortality rate (per 1000)

- ***Please identify three additional impact / outcome indicators that can be used to assess the impact / outcome of the GAVI HSS support in improving immunisation and other child and maternal health services in Table 6.1 below.***
- ***Please list up to 6 output and process indicators in Table 6.2 & 6.3 below.***
- *For all indicators, please give a data source, the baseline value of the indicator and date, a target level and date, as well as a numerator and denominator.*
- *Some indicators may have more than one data source.*
- *Baseline values should be noted for all indicators and there should be a process indicator for each objective*

Note: Definitions of impact, outcome, and output can be found at the following website: www.unep.org/Terminology.pdf. A monitoring HSS toolkit is available on the WHO website http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Introduction.pdf

Note: Examples of outcome, output and process indicators are shown below. Existing sources of information should be used to collect the information on the selected indicators wherever possible. In some countries there may be a need to carry out health facility surveys, household surveys, or establish demographic surveillance. If extra funds are required for these activities, they should be included in this application.

Examples of Outcome Indicators – related to GAVI HSS Objectives (note these are only examples)

Target	Possible indicators
Improve access to MCH	% measles coverage (children less than 2 years);

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

services	% births attended by a skilled birth attendants; % contraceptive use among women 15-44 years of age; % of children under 5 sleeping under ITNs
Improve the quality of health services	% of the population reporting they received health services of good quality; DTP3-DTP1 drop-out rate;
Improve equity of coverage of PHC services	DTP3 coverage rates in % by income quintile

Examples of Output Indicators (note these are only examples)

Strategy	Indicator	Numerator	Denominator	Data Source
Advocacy for greater health expenditure for primary health care	General government health expenditure as a proportion of total government expenditure	The sum of all government health expenditures	Total government expenditure	Government budget
Strengthen the national HMIS	% of districts that submit timely, complete, accurate reports to national level	The number of districts that submit timely, complete, accurate reports to national level	The total number of districts	Health Information System
Strengthening supervision of community health nurses	Systematic Supervision	Number of health centres visited at least 6 times in the last year using a quantified checklist	Total number of health centres	Health facility survey
Strengthened human resource capacity	Knowledge of Health Workers	Mean score of health workers in public and NGO health centres on verbal knowledge test including case scenarios		Health facility survey
Strengthen stock management and logistics systems	% of facilities that have all tracer medicines and commodities in stock: on the day of visit, and in the last three months	The number of facilities with the selected tracer drugs in stock (present and non-expired) on the day of visit /during a specified reference period (last three months).	The total number of facilities	Health Information System & Health facility survey

Examples of Process Indicators (note these are only examples)

Activity	Possible indicators
Construct 280 health posts in rural areas	Number of health posts constructed
Procure 1000 motorcycles for community health nurses	Number of motorcycles procured
Train health workers on family planning methods	Number of health workers trained
Procure safe delivery kits	Number of safe delivery kits procured and delivered

6.1: Impact and Outcome Indicators (data should be consistent with other GAVI applications and annual progress reports from the country)

Indicator	Data source	Baseline Value[25]	Source[26]	Date of Baseline	Target	Date for Target
1. National DTP3 coverage rate (%)	Annual joint report EPI - WHO - UNICEF	88%	EPI	2007	90%	2011
2. Number / % of districts reaching ≥80% DTP3 coverage rate	Joint report WHO-UNICEF-EPI	84%	EPI	2007	90%	2011
3. Under five mortality rate (per 1000)	DHS III report	163‰	Ministry of Planning (NIS)	2005	140‰	2011
4. First antenatal consultation coverage rate (ANC1)	2006 health statistics yearbook	70%	Ministry of Health (NHIS)	2006	85%	2011
5. Rate of assisted deliveries	2006 health statistics yearbook	20%	Ministry of Health (NHIS)	2006	40%	2011
6. Rate of C-sections	2006 health statistics yearbook	1,5%	Ministry of Health (NHIS)	2006	3%	2011

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

6.2 : Output Indicators (one per objective)

Indicator	Numerator	Denominator	Data source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. Availability of marker drugs in health facilities	Number of days without marker drugs stocks out during the period	Number of days of the period	Monitoring reports	50%	Health Information Section (HIS)	2006	90%	2011
2. Proportion of health facilities supervised according to national standards	Number of health facilities supervised according to national standards	Total number of health facilities in the zone	RHTC report	50%	RHD	2008	90%	2011

6.3 : Process Indicators (one per objective)

Indicator	Numerator	Denominator	Data source	Baseline Value	Source	Date of Baseline	Target	Date for Target
1. Proportion of health centers having at least 3 health agents trained to provide essential care services	Number of health centers having at least 3 health agents trained to provide essential care services	Number of health centers in the zone	Annual RHD reports	30%	RHD	2008	80%	2011
2. Proportion of health districts having a district health development plan	Number of health districts having a district health development plan	Total number of health districts in the zone	District Health Development Plans	25%	DHD	2008	100%	2011

To the applicant: Section 6.4:

- *Please describe how the data for the identified indicators will be collected, analyzed and used. Existing data collection and analysis methods should be used wherever possible. Please indicate how data will be used at local levels and ways of sharing with other stakeholders in the last column of Table 6.4 below.*
- *Data collection: the level data is collected at and whose responsibly it is to collect it*
- *Data Use: the level this data is analysed at in disaggregated form, and who is responsible at local and central levels for ensuring the data is assessed and analysed*
- *Data Use: how will this indicator's data be used in assessing performance, and in revising or developing plans and strategies*

6.4: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and Outcome			
1. National DTP3 coverage rate (%)	The monthly report includes an item on immunization. Immunized children are registered on operational forms, which are compiled in a report transmitted at the end of each month to the district for a district compilation which is transmitted to the regional level and at the national EPI coordinating body.	Data are analyzed with computer tools to bring to light trends by geographical zones et through time and are compared to coverage standards expected at each level	Results are used for decision making relating to resources allocation, training, sensitization at the community level. Data are transmitted to partners through the annual joint report.
2. Number / % of districts reaching ≥80% DTP3 coverage rate	On the basis of monthly district reports transmitted at the regional and central levels, a compilation of coverage is made every year	Annual district coverage data are analyzed by their distribution in the 3 performance scales of EPI	Results are used for targeting health districts with low coverage and strengthening interventions
3. Under five mortality rate (per 1000)	Data are collected through a national survey (DHS)	Data are analyzed to measure trends and variation by geographical zones and socio-economic status in relation to MDG targets.	Results are used to formulate and evaluate policies
4. First antenatal consultation coverage rate (ANC1)	The monthly NHIS report includes an item on antenatal consultation. Pregnant women having been in consultation are registered on ANC forms, which are compiled in a report transmitted at the end of each month to the district for a district/regional compilation which is transmitted to the Health Information Section (HIS) of the Ministry	Data are analyzed to bring to light trends by geographical zones et through time and are compared to coverage standards expected at each level	Results are used for decision making relating to resources allocation, training, sensitization at the community level. Data are transmitted to partners through the health statistics yearbook.
5. Rate of deliveries assisted by health personnel	The monthly report includes an item on deliveries. Women having delivered are registered on maternity registers. A data compilation is made at the end of each months and the report is transmitted to the district/region for a district and regional compilation and transmission to the Health Information and Statistics Section (HISS) for a national compilation	Data are analyzed to bring to light trends by geographical zones et through time and are compared to coverage standards expected at each level	Results are used for decision making relating to resources allocation, training, sensitization at the community level. Data are transmitted to partners through the health statistics yearbook.
	The monthly hospital report includes an item on	Data are analyzed to bring to light	Results are used for decision making

Indicator	Data collection	Data analysis	Use of data
6. Rate of C-sections	C-section deliveries. Women having delivered by C-section are registered on maternity registers. A data compilation is made at the end of each month and the report is transmitted to the district/region for a regional compilation and transmission to the Health Information and Statistics Section (HISS) for a national compilation	trends by geographical zones et through time and are compared to coverage standards expected at each level	relating to resources allocation, training, sensitization at the community level. Data are transmitted to partners through the health statistics yearbook.
Output			
1. Availability of marker drugs in health facilities	The biannual health facilities monitoring report includes an indicator of drugs availability. Data are collected from health facilities monitoring reports	An analysis is conducted to determine the extent, the length and the frequency of ED stocks out	The analysis enables to take decisions to correct dysfunctions related to the procurement channel
2. Proportion of health facilities supervised according to national standards	The RHD supervision framework includes an item on the number health facilities supervised by the DHD according to standards. A compilation is conducted in the quarterly activity report that the RHD transmits to the central level.	Data are anlayzed by comparing realization to previsions	Data are used to measure the performance of district and health facilities management teams and resources utilization.
Process			
1. Proportion of health centers having BEOC equipment, motorcycles and solar refrigerators	The supervision report framework includes an item on equipment inventory. Data are collected during supervision visits and compilation is done at the end of the activity for each level	Data are analyzed by comparing what exists to national standards	Data are used to evaluate the level of satisfaction of the needs in adequate equipment and to plan future development
2.Proportion of health districts having a district health development plan	The report framework of the development of district health development plan includes an item on the existence of a DHDP. Data are collected during supervision visits and compilation is done at the end of the activity.	Data are analyzed by comparing the number of DHD having a DHDP to the total number of DHD.	Data are used to determine needs for technical and financial support.

To the applicant: Section 6.5:

- *Please indicate if the Monitoring & Evaluation (M&E) system needs to be strengthened to measure the listed indicators and if so describe which areas of the M&E system specifically needs strengthening. (Table 6.5).*

Note: HSS resources may be used to strengthen the Health Information System itself. If the country chooses, the investment should be harmonised with the support from other donors (such as the Global Fund for AIDS, HIV and TB and others). Countries can seek GAVI HSS support for including relevant sex disaggregated data in their Health Information System.

6.5: Strengthening M&E system

The national health information system (NHIS) operates on the basis of the national health pyramid with branches at the district, regional and national levels. Next to the system of management of routine reports, several sub-systems collect data related to their specific activities: routine data, epidemiologic surveillance data, program management, administrative and financial data, and studies.

These different sub-systems should operate in a concerted manner to, on one hand feed the NHIS, and on the other, receive data from the latter.

Monitoring of public health facilities is performed biannually. Two components are followed through this system: health care provision and financial resources.

For care provision, few determinants are examined, namely the target population, the availability of production inputs, the utilization, the coverage and the quality of care.

Regarding financial resources, the level of income and resources utilization is monitored.

Directives on the process are given in a standard document called the “monitoring booklet”.

The results derived from this monitoring which are primarily for internal use of facilities are presented during sessions of local monitoring and evaluation bodies (sub-district synthesis, DHTC and RHTC).

The performance level of this monitoring and evaluation framework does not permit to inform satisfactorily the indicators listed above including childhood consultation, antenatal consultation, deliveries, C-section rates and immunization.

The audit of the nationl health information system conducted in 2008 with the support of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria revealed the following weaknesses:

- The statistics yearbook was not released in the imparted time;
- The statistical output capacity (yearbook, bulletin, performance indicators, health map etc.) was weak ;
- The low completedness and timeliness of reports from deconcentrated facilities;
- The lack of a system of control of the reliability of collected data (data quality);
- The insufficient data dissemination and utilization.

This diagnosis is accompanied by a strengthening plan that includes the following interventions:

- improvement of the statistical output by strengthening the collection, transmission, management and analysis functions;
- improvement of data quality through data validation meetings, personnel training and introduction of the quality approach;
- increase in data utilization and in dissemination by an improvement of access to information[27].

The activities planned in the current proposal contribute to the implementation of NHIS improvement interventions contained in the audit report. These are essentially the provision of data collection tools, and the production of quarterly bulletins.

It has to be noted that GAVI support for this component is in line with a larger partnership framework in which the Global Fund and other partners contribute also to improve statistical output. It is mostly, for the Global Fund, to provide informatics material to health districts and regions and a supervision vehicle to the NHIS at the central level, to recrute a technical assistant to conduct the audit of the NHIS, to provide management tools and to train agents in charge of statistics.

[27] Audit of the National Health Information System, MSHP, 2008.

To the applicant: Section 6.6:

- *Please indicate if the GAVI HSS application includes elements of operational research that address some of the health systems barriers to better inform the decision making processes. (Table 6.6).*

Note: GAVI HSS Support can be used for operational research such as analysis of reasons why populations are not able to access immunisation services (whether this be due to social, economic, political or gender), with overall equity in access being the ultimate goal. This funding could also be used to test/examine of specific strategies to see which might work best.

6.6: Operational Research

Study on the organizational structure of public health facilities

The institutional and operational framework of the Ministry of Health and Public Hygiene is confronted to several constraints related to the growing complexity of the health system and to the multiplicity of initiatives, actors and programs. Difficulties of readability, coordination and management derive from this situation. Therefore, it is necessary to re-think and adapt the organization and operation of the Ministry on the basis of the demands of efficiency and effectiveness.

The proposed study will, in particular, endeavor to define as closely as possible the following dimensions: institutional framework, resources management, community partnership and participation, performance.

The expected results are: a clarification of hierarchical and operational relationships, a clear readability of missions, roles and responsibilities at all levels.

These results will enable to undertake reforms to improve the implementation of the NHDP through the set-up of a more adapted organizational framework, a more operational partnership framework, a more effective coordination and collaboration framework, a more transparent management and a better involvement of the beneficiaries.

Section 7: Implementation Arrangements

To the applicant: sections 7.1 and 7.2

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

Note: GAVI encourages countries to align the implementation arrangements for the GAVI HSS support with existing country mechanisms. Applicants are strongly discouraged from establishing a project management unit (PMU) for the GAVI HSS support. The establishment of PMUs will only be funded under exceptional circumstances, based on a strong rationale.

7.1: Management of GAVI HSS support

Give details on the management costs and mechanisms (especially if a partner will be managing parts of the GAVI HSS proposal)	**Mechanism of transfer of GAVI HSS support funds to the country** A dedicated bank account in international currency will be opened in one of the local commercial banks to receive GAVI HSS support funds. This account will be co-signed by the Minister in charge of health and the WHO representative in Guinea. Each of this two signatories will have an alternate signatory designated by them. **Mechanism of transfer of GAVI HSS support funds from the central level to the periphery** The funds will be transfered from the central level to the peripheral level by the FAD, through the banking system. Dedicated bank accounts in GNF will be opened for this purpose by each sub-beneficiary. Account numbers and routing references must be communicated to the FAD. **Mechanism (and responsibility) of budget utilization and authorization** The planning and the implementation of the GAVI HSS support will be integrated to organic structures of the Ministry in charge of health according to existing mechanisms and procedures. **Mechanism of disbursement of GAVI HSS support funds to the country** The technical committee coordinates the development of the budgetized annual plan and the activity reports and submit them to the HSCC for approval. Once the budgets are approved, the funds are disbursed to the sub-beneficiaries which are in charge of implementing the proposal activities (health services, NGO, associations, companies, other private entities). Purchase of informatic equipment and vehicles will be entrusted to UNICEF which will do grouped orders. Regarding the medical material, drugs and medical consumables, credit lines will be opened in favor of the sub-beneficiaries at the Central Phramacy of Guinea (CPG). It will be in charge of purchasing, according to procedures in effect, and supplying the sub-beneficiaries. Local purchases of goods and services will be performed according to national procedures in effect.

Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc	The director of the Strategy and Development Office (SDO) of the Ministry of Health and Public Hygiene will be responsible for managing GAVI HSS / M&E support from the proposal of the Republic of Guinea. He also ensurse the technical preparation of the HSCC meetings
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	The Health System Coordinating Committee has the following roles: - To approve annual plans of implementation of the GAVI-HSS proposal; - To approve the proposal disbursement plans; - To ensure the monitoring of the implementation of the proposal during its meetings - To assess annually the implementation of the proposal during the annual reviews of the sector - To initiate audits of the management of the financial resources of GAVI-HSS and to validate their results - To initiate assessments (mid-term and final) of the GAVI-HSS proposal
Mechanism for coordinating GAVI HSS support with other health system strengthening activities and programs	The coordination of GAVI HSS support with other interventions will be aligned on mechanisms of coordination of the sector already in place. These are: 1. The organization, at all tiers (central, regional and district) of the health pyramid, of the annual session of the Partners Coordinating Committee (PCC) to i) examine and adopt the technical and financial report of the previous year, ii) examine the constraints and difficulties that hinder the proper implementation of programs and projects OAP, iii) decide on the results to attain during the following year and the adaptations of the intervention strategies of the sector; 2. The organization, twice a year, of the session of the TCC at the central level, of the RHTC at the regional level and the DHTC at the district level to: i) examine, amend and adopt the reports of activity, audit and evaluation of current projects and programs, ii) prepare the review, the meeting of the partners Coordinating Committee and monitor the execution of the decisions taken during these meetings, iii) examine, amend and adopt the reports on progress toward the indicators, iv) define the corrective measures of the deficiencies observed in these reports; 1 The organization of the annual review of the health system which goal is to i) discuss, amend and adopt the balance sheet of the Ministry of Health and Public Hygiene for the year N, ii) disseminate the budget allocated by the state to health for the year N+1, iii) confirm mobilizable resources with partners for the year N+1, iv) proceed, on the basis of these two files (balance and budget) to budgetary arbitration at all levels of the health pyramid, v) finalize the OAP for the year N+1, in light of the results of the budgetary arbitration; 2 Convening extraordinary meetings, as needed.

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

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Regional Directors of Health and Public Hygiene	Ministry of Health and Public Hygiene	No	1. Organize the RHTC 2. Participate to the TCC 3. Participate to the HS annual review
District Directors of Health and Public Hygiene	Ministry of Health and Public Hygiene	No	1. Organize the DHTC 2. Participate to the RHTC 3. Participate to the HS annual review
UNICEF Representative	United Nations Children's Fund	Yes	1. Bring technical and financial support to the realization of child survival activities contained in the proposal 2. Contribute to the improvement of the quality of data relating to child survival, 3. Participate to coordinating bodies (PCC, TCC, Annual reviews and, in his/her zones of intervention, to RHTC)
WHO Representative	World Health Organization	Yes	1. Bring technical support to the development of annual plans of implementation of the proposal, 2. Support the central level in the development of normative documents necessary to the reform of the health sector 3. Bring technical support during the various evaluations of the proposal. 4. Participate to coordinating bodies (PCC, TCC, Annual review)
UNFPA Representative	United Nations Population Fund	Yes	1. Bring technical and financial support complementary to the realization of reproductive health activities 2. Contribute to the improvement of the quality of data relative to reproductive health 3. Participate to coordinating bodies (PCC, TCC, Annual reviews)
USAID Representative	United States Agency for International Development	Yes	1. Bring technical support (through international consultancy) in the resolution of technical problems relative to the proposal implementation 2. Participate to coordinating bodies (PCC, TCC, Annual reviews)

Title / Post	Organization	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Health sector lead	European Commission	Yes	1. Bring technical support (through international consultancy) in the resolution of technical problems relative to the proposal implementation 2. Participate to coordinating bodies (PCC, TCC, Annual reviews)
Health sector lead	French Development Agency	Yes	1. Bring technical support (through international consultancy) in the resolution of technical problems relative to the proposal implementation 2. Participate to coordinating bodies (PCC, TCC, Annual reviews)
Rotary Club Representative	Rotary Club International	No	1. Participate to coordinating bodies (PCC, TCC, Annual reviews) 2. Bring material support to the proposal implementation
HKI Representative	Helen Keller International	No	1. Bring technical support in the resolution of technical problems relative to the proposal implementation 2. Participate to coordinating bodies (PCC, TCC, Annual reviews)
Private Facilities Representative	Saint Gabriel Dispensary	No	1. Support integration of essential care activities including immunization in private facilities 2. Provide stastistical data on activities developped in private facilities.
Representative of the Board of Physicians	Board of Physicians	Yes	Participate to coordinating bodies (PCC, TCC, Annual reviews)
Representative of the Board of Pharmacists	Board of Pharmacists	Yes	Participate to coordinating bodies (PCC, TCC, Annual reviews)
AGBEF Representative	AGBEF	Yes	1. Participate to coordinating bodies (PCC, TCC, Annual reviews) 2. Bring technical support to improve RH services 3. Bring support to the implementation of the proposal particularly in the component care provision and population sensitization.

To the applicant: Section 7.3:

Please provide information on the financial management of GAVI HSS support in table 7.3

Note: Applications will not be reviewed or approved by the Independent Review Committee (IRC) if the required documentation on the financial arrangements are not submitted together with the completed application form.

Note: The GAVI Alliance adopted a Transparency and Accountability Policy (TAP) for cash-based support, including GAVI HSS support, which took effect as of 1 January 2009.

Note: The TAP policy outlines a set of minimum requirements for the financial management of GAVI HSS support:

- *Funding should be used for objectives stated within a proposal.*
- *Funds must be managed in a transparent manner, and accurate and verifiable financial reports should be provided on a regular basis, as specified by individual funding arrangements.*
- *Funds must be managed within accounts that meet national legal requirements for auditing, accounting and procurement.*

Note: Besides the above minimum financial management requirements:

- *Funds should be reflected in the national budget (be on budget).*
- *Funds should be additional to the government allocation to the health sector, as well as to the contributions of other partners: i.e. no funding should be diverted away from the health sector if HSS funds are received.*

Note: It is also a GAVI Alliance requirement that all countries receiving HSS support will need to go through a GAVI Financial Management Assessments (FMA) prior to the release of the first years support.

7.3: Funding arrangements

Mechanism / procedure	Status / Description
Has a GAVI FMA been conducted: yes / no	No
When was the last FMA conducted? mm/yyyy	
If yes: Has an Aide Memoire been signed: yes[28] / no (Document Number.....)	
If yes: Will the present Aide Memoire govern the financial management of the GAVI HSS funds: yes / no	
If no: Reasons for not following all the agreements in the last Aide Memoire	
Next FMA scheduled for: mm/yyyy	
Has a joint financing mechanism been established for the health sector: yes / no	
If yes: Will this joint financing mechanism be used for managing GAVI HSS funds: yes[29] / no (Document Number.....)	
If no: Reasons for not using the joint financing mechanism	
Please provide a detailed description of the financing mechanism proposed for the management of GAVI HSS funds[30] if all the agreements in the last Aide Memoire is not followed or a FMA has yet to be conducted.	A FMA will be conducted before the implementation of the proposal.
Title(s) of document(s) governing the annual budgeting process for the use GAVI HSS funds[31] (Document Number.....)	
Title(s) of document(s) governing the financial management (accounting, recording and reporting) of the GAVI HSS funds[32] (Document Number.....)	
Title(s) of document(s) governing the audit of the GAVI HSS funds[33] (Document Number.....)	

[28] Please summit a copy of the Aide Memoire

[29] Please summit a copy of the agreement/memorandum of understanding, which governs the joint financing mechanism and a copy of the document which describes how the joint financing mechanism is currently functioning.

[30] Please note that the mechanism selected must comply with the minimum requirements of GAVI's Transparency & Accountability Policy

[31] Please summit a copy of the procedures and legislation, which applies to the annual budgeting process for the use of GAVI HSS funds and documentation, which describes how the budgeting process for GAVI HSS funds would be conducted

[32] Please summit a copy of the procedures, which apply to the financial management (accounting, recording and reporting) of GAVI HSS funds and documentation, which describes how the financial management of GAVI HSS funds would be functioning.

[33] Please summit a copy of the procedures, which apply to the external audit of GAVI HSS funds and documentation, which describes how the external audit of GAVI HSS funds would be conducted

Mechanism / procedure	Status / Description
Frequency of internal audits planned for GAVI HSS funds?	
Frequency of external audit[34] planned for GAVI HSS funds?	
Title(s) of document(s) governing procurement procedures for GAVI HSS funds[35] (Document Number.....)	

[34] "External audit" defined as the audit conducted by the Government's Supreme Auditing Agency.

[35] Please summit a copy of the procurement procedures for GAVI HSS funds and documentation, which describes how the procurement would be processed

To the applicant: Section 7.4:

- *Please describe arrangements for reporting on the GAVI HSS funds, including the responsible Government Official who will be responsible for compiling the Annual Progress report (APR).*

Note: Implementation of GAVI HSS supported activities will be reported to the GAVI Alliance through the Annual Progress Report. The report will provide information on progress in reaching targets set in the GAVI HSS Application Form. The report will also provide financial management information on the use of GAVI HSS funds.

Note: The deadline for the submission of the Annual Progress Report for the previous calendar year is 15 May of each year. All countries should submit an APR, even if the GAVI HSS support was received towards the end of the previous year.

7.4 : Reporting arrangements

The reports of execution of activities of the GAVI-HSS proposal will include a technical part and a financial part.

At the technical level, each institution which has the responsibility of the implementation of the activities of the proposal will develop a technical report on activities realized during the year. Each report will be establish on the basis of the objectives included in the annual plan of action approved by the HSCC during the health sector annual review meetings. The various reports will be compiled by the Technical Secretariat of the HSCC.

At the financial level, each institution must justify to the FAD the utilization of the GAVI-HSS funds made available to it and the FAD will be in charge of compiling and establishing a financial report of the period.

Annual reviews will be organized to allow the HSCC Secretariat to approve the technical and financial reports before the end of April. This should allow the transmittal of the annual report of implementation of the proposal activities to GAVI before May 15 of each year.

The various reports will cover the period going from January 1st to December 31st. After their approval by the HSCC, the Minister of Health transmits them to GAVI Alliance.

To the applicant: Section 7.5:

- *Please identify what technical assistance will be required during the life of GAVI HSS support, as well as the anticipated source of technical assistance if known (Table 7.5).*

Note: The GAVI Alliance Secretariat can provide countries with one-time financial support to assist with the application process. The procedures for this support are described in the GAVI HSS Guidelines under Technical Support.

Note: Request for resources for technical support to implement and monitor the GAVI HSS support should be made using table 7.5 below.

7.5: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Conduct of the Financial Management Assessment (FMA)	3 weeks	September 2009	International Consultation
2. Conduct of the NHDP Assessment	1 month	December 2011	International Consultation
3. Assessment and re-programming of the cMYP	1 month	1st semester 2010	National Consultation
4. Conduct of the annual audit of the accounts of the component	2 weeks after the end	4th trimester 2011	International Consultation

Section 8: Budgeting and Funding for GAVI HSS supported activities

To the applicant: Section 8.1:

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

Note: Please ensure that all costs for the implementation of GAVI HSS support, including technical assistance, are included in the budget. Please convert all budget figures to US$ (at the current exchange rate), and ensure that GAVI deflators are used for future costs (see guidelines on the GAVI website: www.gavialliance.org).

Note: The amount requested in table 8.1 should not exceed the amount specified in table 8.2.

Note: Management costs should be kept to a minimum. All management costs should be detailed in the budget and whether the management is through partners; including cost of having other partners responsible for managing part of the implementation of the GAVI supported activities.

Note: Unit costs and calculations should be attached in a spreadsheet.

For each subsequent year, provide the estimated expenditure (using unit costs) for each activity. Please carefully check that the totals of columns (expenditure by year) are consistent with the totals by Row (for activity and SMART Objective). Calculation errors are a frequent source of delays, as the IRC will ask for clarifications

Ensure the total budget for the entire HSS proposal does not exceed the country allocation calculated in Section 8.2 below.

8.1 : Budget for implementing GAVI HSS supportCalcul Coûts Soutien GAVI-RSS VF.xls

Support area	Units	Unit Cost	Quantity			Cost (in USD)		
			Year 1 of implementation (2010)	Year 2 of implementation (2011)	Total	Year 1 of implementation (2010)	Year 2 of implementation (2011)	TOTAL
Objective 1: To increase essential care accessibility from 40% in 2006 to 60% by the end of 2011 in 5 health districts with low immunization coverage								
SPD 1.1: IMMUNIZATION								
Activity 1.1.1: Provide 50 solar refrigerators to 50 HCs	kit	6,000	50		50	300,000		300,000
Activity 1.1.2: Grant performance bonuses to 150 agents of 50 HF in rural areas	h/year	480	150	150	300	72,000	72,000	144,000
Activity 1.1.3: Support private facilities from civil society organizations to conduct sensitization activities and provide essential health services	facility/year	1,000	5	5	10	5,000	5,000	10,000
Activity 1.1.4: Provide 50 motorcycles to 50 HC	each	3,300	25	25	50	82,500	82,500	165,000
Activity 1.1.5: Ensure proper operation and maintenance of 50 motorcycles	moto/year	280	50	50	100	14,000	14,000	28,000
Activity 1.1.6: Support the maintenance of 50 solar refrigerators	fridg./year	200	50	50	100	10,000	10,000	20,000
Activity 1.1.7: Support civil society organization in developping health mutual insurance associations in the zone	organ.	10,000	2	2	4	20,000	20,000	40,000
Activity 1.1.8: Organize sensitization through microprograms at 4 rural radio stations	program	20	104	104	208	2,080	2,080	4,160
Activity 1.1.9: Support HC management committee in active research and sensitization activities	man. com.	90	50	50	100	4,500	4,500	9,000
Activity 1.1.10: Organize 12 sessions of community sensitization on MCH/FP activities per HC and per year	session	10	600	600	1,200	6,000	6,000	12,000
SPD 1.1 Sub-Total						516,080	216,080	732,160
SPD 1.2: Reproductive Health								

Support area	Units	Unit Cost	Quantity			Cost (in USD)		
			Year 1 of implementation (2010)	Year 2 of implementation (2011)	Total	Year 1 of implementation (2010)	Year 2 of implementation (2011)	TOTAL
Activity 1.2.1: Organize 2 training workshops for 25 providers per session during 10 days in the RH field	h/d	63	250	250	500	15,750	15,750	31,500
Activity 1.2.2: Allocate a start-up provision of pregnancy monitoring and delivery tools to 50 HC in the zone	kit	200	50		50	10,000		10,000
Activity 1.2.3: Provide 2 ambulances to 2 DH	ambulance	40,000	2		2	80,000		80,000
Activity 1.2.4: Ensure proper operation and maintenance of 2 ambulances in DH	veh./year	7,248	2	2	4	14,496	14,496	28,992
Activity 1.2.5: Provide 20 BEOC equipements to 20 HCs	kit	10,000	20		20	200,000		200,000
Activity 1.2.6: Provide 2 CEOC equipements to 2 DH	kit	30,000	2		2	60,000		60,000
Activity 1.2.7: Provide to 5 DH C-section kits for obstetrical emergencies	kit	60	1,403	1,403	2,806	84,180	84,180	168,360
SPD 1.2 Sub-Total						464,426	114,426	578,852
SPD 1.3: 3 : Curative care								
Activity 1.3.1: Revise and adopt standardized treatment regimens (flowcharts and therapeutic protocols)	workshop	7,000	1		1	7,000		7,000
Activity 1.3.2: Reproduce and disseminate standardized treatment regimens to 50 HC, 5 DHD, 5 DH and 2 RHD	copy	25	70		70	1,750		1,750
Activity 1.3.3: Organize 3 training sessions for 25 health agents per session during 10 days in IMCI, care rationalization and EDs management	h/d	63	500	500	1,000	31,500	31,500	63,000
Activity 1.3.4: Allocate a start-up provision of drugs and medical consumables to 50 HCs	kit	5,000	50		50	250,000		250,000

Support area	Units	Unit Cost	Quantity			Cost (in USD)		
			Year 1 of implementation (2010)	Year 2 of implementation (2011)	Total	Year 1 of implementation (2010)	Year 2 of implementation (2011)	TOTAL
Activity 1.3.5: Procure EDs and medical consumables to hospitals	kit	15,000	5		5	75,000		75,000
SPD 1.3 Sub-Total						365,250	31,500	396,750
Objective 1 Total:						1,345,756	362,006	1,707,762
Objective 2: To strengthen management capacity in 5 health districts, 2 regional health directorate and at the central level by the end of 2011								
SPD 2.1: Operational Research								
Activity 2.1.1: Conduct a study on the organizational structure of public health facilities	study	10,000	1		1	10,000		10,000
Activity 2.1.2: Conduct a study on the feasibility of the implementation of health mutual insurance associations in the zone	study	10,000	1		1	10,000		10,000
Activity 2.1.3: Assess the implementation of the 2007-2011 cMYP and re-program the 2012-2016 cMYP	study	14,000		1	1		14,000	14,000
Activity 2.1.4: Assess the implementation of the 2007-2011 NHDP and re-program the 2012-2017 NHDP	study	18,572		1	1		18,572	18,572
SPD 2.1 Sub-Total						20,000	32,572	52,572
SPD 2.2: Monitoring and Evaluation System								
Activity 2.2.1: Organize biannual supervision visits from the central level to the intermediary and peripheral levels	visit	2,000	2	2	4	4,000	4,000	8,000
Activity 2.2.2: Organize quarterly supervision visits from the regional level to the HDs of the targeted zone	visit	1,200	8	8	16	9,600	9,600	19,200

Support area	Units	Unit Cost	Quantity			Cost (in USD)		
			Year 1 of implementation (2010)	Year 2 of implementation (2011)	Total	Year 1 of implementation (2010)	Year 2 of implementation (2011)	TOTAL
Activity 2.2.3: Organize supervision visits every two months from the District to the hospital and the HCs of the targeted zone	visit	600	30	30	60	18,000	18,000	36,000
Activity 2.2.3: Provide information system and management tools	kit	20	70	70	140	1,400	1,400	2,800
Activity 2.2.4: Produce quarterly statistical bulletins	release	2,000	4	4	8	8,000	8,000	16,000
Activity 2.2.5: Provide 5 supervision vehicles (4x4 Pick-up) to 5 health districts	vehicle	25,000	5		5	125,000		125,000
Activity 2.2.6: Ensure proper operation and maintenance of the 5 supervision vehicles of the 5 DHD	veh./year	7,248	5	5	10	36,240	36,240	72,480
SPD 2.2 Sub-Total						202,240	77,240	279,480
SPD 2.3: Coordination/management								
Activity 2.3.1: Support HSCC meetings logistics	meeting	200	4	4	8	800	800	1,600
Activity 2.3.2: Support the organization of 4 RHTC in the targeted zone	session	2,000	2	2	4	4,000	4,000	8,000
Activity 2.3.3: Support the organization of 10 DHTC in the targeted zone	session	1,000	10	10	20	10,000	10,000	20,000
Activity 2.3.4: Develop a manual of implementation of mutual insurance associations	document	5,258	1		1	5,258		5,258
Activity 2.3.5: Organize 2 multisectorial concertation meetings per year at the central level and in the targeted zone	meeting	500	16	16	32	8,000	8,000	16,000

Support area	Units	Unit Cost	Quantity			Cost (in USD)		
			Year 1 of implementation (2010)	Year 2 of implementation (2011)	Total	Year 1 of implementation (2010)	Year 2 of implementation (2011)	TOTAL
Activity 2.3.6: Support the development of district health development plans (DHDP) in the targeted zone	study	3,000	5		5	15,000		15,000
Activity 2.3.7: Perform an annual audit of the accounts of the project	study	7,000	1	1	2	7,000	7,000	14,000
Activity 2.3.8: Organize a 4 days workshop to develop the documents of creation and operation of a multisectorial concertation framework at the different levels	workshop	7,000	1		1	7,000		7,000
Activity 2.3.9: Organize a training session for regional and districts managers in management of district health systems during 10 days	workshop	7,260	1		1	7,260		7,260
SPD 2.3 Sub-Total						64,318	29,800	94,118
TOTAL 2						286,558	139,612	426,170
Total						1,632,314	501,618	2,133,932

To the applicant: Section 8.2:

- *Please calculate the amount of funds available per year from GAVI for the proposed GAVI HSS activities, based on the annual number of births and GNI per capita[36] as follows (Table 8.2):*

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

Note: The following example assumes the birth cohort in the year of GAVI application is 100,000, and gives the total fund allocations if the GNI < $365 per capita and if the GNI > $365 per capita.

Examples: GAVI HSS country allocation calculation (note these are examples only)

GAVI HSS Allocation (GNI < $365 per capita)	**Allocation per year (US$)**				
	2007	**2008**	**2009**	**2010**	**TOTAL FUNDS**
Birth cohort	100,000	102,000	104,000	106,000	
Allocation per newborn	$5	$5	$5	$5	
Annual allocation	$500,000	$510,000	$520,000	$530,000	**$2,060,000**

GAVI HSS Allocation (GNI > $365 per capita)	**Allocation per year (US$)**				
	2007	**2008**	**2009**	**2010**	**TOTAL FUNDS**
Birth cohort	100,000	102,000	104,000	106,000	
Allocation per newborn	$2.5	$2.5	$2.5	$2.5	
Annual allocation	$250,000	$255,000	$260,000	$265,000	**$1,030,000**

8.2: Calculation of GAVI HSS country allocation (this number should be consistent with data used in other GAVI applications and annual progress reports)

GAVI HSS Allocation	**Allocation per year (US$)**			
	Year of GAVI application 2009	Year 1 of implementation 2010	Year 2 of implementation 2011	**TOTAL**
Birth cohort		420,894	432,679	853,573
Allocation per newborn		2.5	2.5	2.5
Annual allocation		**1,052,235**	**1,081,697**	**2,133,932**

Birth cohort:
Source: ……

[36] See GAVI HSS Guidelines for countries respective funding levels under ***Allocation***

To the applicant: Section 8.3:

- *Please summarize the overall available funding for the Heath System Strengthening efforts related to improving the immunization coverage and the coverage of other child health services.*

- *Immediately following the table, please provide a concise explanation to demonstrate how the proposed GAVI HSS funding will be used to complement these existing and/or planned efforts to strengthen health systems capacity.*

Note: GAVI HSS funds must be additional to the government's health budget – and the funds should not displace resources allocated to the health sector.

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

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

Funding Sources	**Allocation per year (US$)**						
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	**TOTAL FUNDS**
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	
GAVI		1,052,235	1,081,697				**2,133,932**
Government	19,522,000	15,852,000	29,644,000				**65,018,000**
Specific indication on what contributions this source of funding provides for health systems strengthening							
World Bank	2,762.68						**2,762.68**
Specific indication on what contributions this source of funding provides for health systems strengthening							
Global Fund	13,424,706,84	3,914,541.26					**17,339,248.10**
Specific indication on what contributions this source of funding provides for health systems strengthening							
WHO	3,398,000	6,020,000	6,020,000	NA	NA		**15,438,000**
UNICEF	2,405,000	2,405,000	2,405,000				**7,215,000**
UNFPA		1,935,668	2,000,000				**3,935,668**
Total Other	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000		**10,000,000**

Source of information on funding sources:

GAVI	HSS support proposal submitted
Government	Public Investment Program 2008-2011
World Bank	Public Investments Scheduling Card SNHDP 2007-2009
Global Fund	Round 6
WHO	Cooperation Plans WHO-Guinea 2008-2009 and 2010-2011
UNICEF	Cooperation Plan UNICEF-Guinea 2007-2011
UNFPA	Forecasted budget of the Cooperation Plan 2007-2011
Other	Costs recovery/Management directory

To the applicant: Section 8.4:

- Please provide a concise explanation to demonstrate how the proposed GAVI HSS funding will be used to complement these existing and/or planned efforts to strengthen health systems capacity.

8.4 : Describe how GAVI HSS funding will complement other sources of HSS funding

The financing for health system strengthening contemplated in this proposal is not isolated and positions itself in the perspective of complementarities between funders and partners and registers in the synergy of interventions in the targeted zone as described in the criteria for choosing the targeted districts.
At the level of financial management, GAVI support will be included in the budget of the Ministry of Health and Public Hygiene and the disbursements will be done according to management procedures in effect at the level of the department of health.
Regarding the synergy inside the zone supported by GAVI, several partners and funders complement each others through their financing:

- The State takes care of the payment of permanent personnel salaries and the local collectivities the salaries of support personnel. The State also subsidizes the operation of district hospitals beyond salaries as well as part of the investments.
- UNICEF brings its support in terms of immunization services provision along with other essential services in the entire country and a focused support in ten (10) health districts including Kindia for the implementation of the ACSDS.
- WHO funds provide a support to the health system at the level of orientations and policies, disease control and reproductive health. Actions implemented with WHO funds will be in relation to the global management of the system.
- UNFPA brings its support in the domain of reproductive health by providing essential care and the definition of standards in RH in several districts including Boke.
- SNHDP covers eighteen (18) districts that are either poor or in post-conflict situation and provides equipment and drugs and train and recruit personnel.
- USAID covers the provision of reproductive health services in four (4) districts other than the ones considered in this proposal.
- The financing by GAVI comes, in complement of other partners (UNICEF, WHO, UNFPA, USAID) intervening in the targeted zones, to strengthen the extension of the health coverage by building, renovating and providing equipment to facilities, the retention of agents to guarantee safe deliveries, the proper management of referrals, the regularity of immunization activities in advanced and mobile strategies and the monitoring and evaluation of activities. Moreover, this support will complement the support and supervision functions.

The totality of these actions, attainable because of the multiple financing sources,will allow improving substantially the performance of the health system for the benefit of the population.

Section 9: Terms and Conditions of GAVI Support

To the applicant:

- *This Section sets out the terms and conditions for GAVI HSS support. By signing and endorsing this application form, you confirm you have read and agree to GAVI's terms and conditions for HSS support.*

TERMS AND CONDITIONS
GAVI ALLIANCE

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance for this application will be used and applied for the sole purpose of fulfilling the programme(s) described in this application . Any significant change from the approved programme(s) must be reviewed and approved in advance by the GAVI Alliance. All funding decisions for this application are made at the discretion of the GAVI Alliance Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THIS PROPOSAL

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application , or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance shall not be offered by the Country to any third person, nor will the Country seek in connection with this application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of

GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the government confirm that this proposal is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application .

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

ARBITRATION

Any dispute between the Country and the GAVI Alliance arising out of or relating to this application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the GAVI Alliance or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The language of the arbitration will be English.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The GAVI Alliance will not be liable to the Country for any claim or loss relating to the programmes described in this application , including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in this application.

USE OF COMMERCIAL BANK ACCOUNTS

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

Section 10: Endorsement of the Application

To the applicant: sections 4.1, 4.2 and 4.3

- *The GAVI HSS proposal cannot be reviewed without the necessary signatures and endorsement from the Minister of Health and Minister of Finance, the Chair and members of the Health Sector Coordinating Committee (HSCC)*
- *All HSCC members should sign the minutes of the meeting where the GAVI HSS application was endorsed. This should be submitted with the application and any issues identified during the meeting that may affect the proposal's implementation or monitoring should be highlighted by HSCC members (numbered and listed in Annex 1).*
- *Please give the name and contact details of the person for GAVI to contact if there are queries.*

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

10.1: Government endorsement

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

Please note that this application will not be reviewed or approved by the Independent Review Committee without the signatures of both the Minister of Health & Finance or their delegated authority.

Ministry of Health:	***Ministry of Finance:***
Name: Médecin-Colonel Dr Abdoulaye Chérif DIABY	**Name:** Capitaine Mamadou SANDE
Title / Post: Minister of Health and of Public Hygiene	**Title / Post:** Minister of the Economy and Finance
Signature:	**Signature:**
Date: August 28, 2009	**Date:** August 28, 2009

10.2: Endorsement by Health Sector Coordinating Committee (HSCC) or country equivalent

Members of the Health Sector Coordinating Committee or equivalent endorsed this application at a meeting on August 26, 2009. The signed minutes are attached as Annex 1.

Chair of HSCC (or equivalent):

Name: Dr Mohamed Lamine YANSANE **Post / Organisation:** Chief of Staff of the Ministry of Health and Public Hygiene

Signature: Date:

10.3: Government official to contact in case of programmatic enquiries:

Name: Dr Boubacar SALL **Title:** Director of the Strategy and Development Office of the MSHP

Tel No: 224 60 27 15 83 **Address** : Ministère de la Santé et de l'Hygiène Publique – BP : 585 – Conakry - République de Guinée.

Fax No:
Email: bousall2@yahoo.fr

10.4: Government official who is the focal point for overseeing the financial management of GAVI HSS funds:

Name: Mr Bappaté BARRY **Title**: Director of Financial Affairs Division Ministry of Health and Public Hygiene

Tel. No: 224 60 52 70 18 **Address:** Ministère de la Santé et de l'Hygiène Publique – BP : 585 – Conakry - République de Guinée.

Fax No.:

ANNEX 1: Documents Submitted in Support of the GAVI HSS Application and final checklist

To the applicant:

- *Please number and list in the table below all the documents submitted with this application. Please be consistent with the title and number of the background / supporting document when referring to it in the proposal.*

Note: The Proposal and attachments must be submitted in English or French, and be accompanied with soft copies of the submitted documents.

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Development Plan [Plan National de Développement Sanitaire (PNDS)]	Yes	2003 - 2012	1
Demographic and Health Survey [Enquête Démographique et de Santé (EDS III)]	Yes	2005	2
Socio-economic development report [Rapport du développement socioéconomique]	Yes	2006	3
Assessment of the health component of PRS 1 [Evaluation de la composante Santé de la SRP 1]	Yes	2006	4
2006 health statistics yearbook [Annuaire des statistiques sanitaires 2006]	Yes	2006	5
Medium Term Expenditure Framework [Cadre de Dépenses à Moyen Terme (CDMT)]	No	2006	6
Poverty Reduction Strategy Paper II [Document de Stratégie de Réduction de la Pauvreté II (DSRP II)]	Yes	2006	7
Human Resources in Health [Ressources humaines en santé]	Yes	2006	8
National road-map for accelerating the reduction of maternal, neonatal and infant-juvenile mortality in Guinea [Feuille de route nationale pour accélérer la réduction de la mortalité maternelle, néonatale et infantojuvénile en Guinée]	Yes	2006 – 2015	9
Rapid assessment of health district operationality [Evaluation rapide de l'opérationnalité des districts de santé]	Yes	2007	10
Quality Competition [Concours Qualité]	Yes	2007	11
Comprehensive Multi-Year Plan [Plan Pluriannuel Complet]	Yes	2007 – 2011	12
Study on secure drugs purchase funds [Etude sur les fonds sécurisés d'acquisition des médicaments]	Yes	2008	13
Audit of the Health Information System [Audit du Système d'Information Sanitaire]	Yes	2008	14
HSCC minutes, signed by Chair of HSCC [Procès-verbaux du CCSS, signés par le Président du CCSS]	Yes	2008 - 2009	15
Code of Collectivities [Code des Collectivités]	Yes		16
Cooperation strategy WHO-Guinea [Stratégie de coopération	Yes	2008 - 2013	17

OMS – Guinée]			
Nutritional survey and main indicators for child survival and development [Enquête nutritionnelle et principaux indicateurs pour la survie et le développement de l'enfant (MICS)]	Yes	2008	18

ANNEX 2: Banking Form

Note: It cannot be stressed enough that without a banking form that contains complete, accurate banking details (IBAN, SWIFT code, corresponding US bank and account details) it is impossible to transfer funds. Lack of full and correct information in this section WILL cause many unnecessary delays. This needs to be endorsed by UNICEF country representative on letter headed paper.

GLOBAL ALLIANCE FOR VACCINES AND IMMUNISATION	**Banking Form**

SECTION 1 (To be completed by payee)

In accordance with the decision on financial support made by the Global Alliance for Vaccines and Immunisation dated . . . . . ., the Government of ……..
hereby requests that a payment be made, via electronic bank transfer, as detailed below:

Name of Institution: ***(Account Holder)***		
Address:		
City - Country:		
Telephone No.:	**Fax No.:**	
Amount in USD:	(To be filled in by GAVI Secretariat)	**Currency of the bank account:**
For credit to: ***Bank account's title***		
Bank account No.:		
At: ***Bank's Name***		

Is the bank account exclusively to be used by this program? **YES ( ) NO ( )**

By whom is the account audited? ----------

Signature of Government's authorizing official:

Name:	----------	**Seal:**
Title:	----------	
Signature:	----------	
Date:	----------	

SECTION 2 (To be completed by the Bank)

FINANCIAL INSTITUTION	**CORRESPONDENT BANK (In the United States)**
Bank Name:	
Branch Name:	
Address:	
City – Country	
Swift code:	
Sort code:	
ABA NO.:	
Telephone No.:	
Fax No.:	

I certify that the account No. . . . . .Is held by (Institution name) . . . . . .at this banking institution.

The account is to be signed jointly by at least …… (number of signatories) of the following authorized signatories:	**Name of bank's authorizing official:**
1 Name:	**Signature:**
Title:	**Date:**
2 Name:	**Seal:**
Title:	
3 Name:	
Title:	
4 Name:	
Title:	

COVERING LETTER

(To be completed by UNICEF representative on letter-headed paper)

TO:
GAVI Alliance Secretariat,
Att. Dr Julian Lob-Levyt
Executive Secretary
Chemin de Mines 2.
CH 1202 Geneva,
Switzerland

On the …… I received the original of the BANKING DETAILS form, which is attached.

I certify that the form does bear the signatures of the following officials:

	Name	**Title**
Government's authorizing official	----------	----------
Bank's authorizing official	----------	----------

Signature of UNICEF Representative:

Name ----------

Signature ----------

Date ----------