

**Health Systems Funding Platform (HSFP)**

**Health Systems Strengthening (HSS) Support**

**COMMON PROPOSAL FORM**

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

**HSS Funding requests to the Global Fund using the Common Proposal Form and Guidelines can only be made when the application materials are launched on15 August 2011**

This form is structured in three parts:

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

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

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| **Part A - Summary of Support Requested and Applicant Information** | | | | |
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| **Applicant:** | ***Ministry of Health and Sanitation*** | | | |
| **Country:** | ***Sierra Leone*** | | | |
| **WHO region:** | ***AFRO*** | | | |
| **Proposal title:** | **Accelerating progress towards MDG 4,5 and 6 in Sierra Leone** | | | |
| **Proposed start date:** | ***October/2012*** | | | |
| **Duration of support requested:** | ***Number of Years 3 years*** | | | |
| **Funding request:** | **Amount requested from GAVI:** | **$ 5,399,371** | **Amount requested from Global Fund:** |  |
| **Currency:** |  | |  | |

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| **Contact details** | |
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| **Executive Summary**  *→ Please provide an executive summary of the proposal.* |
| Sierra Leone has some of the poorest health indicators in the world, with life expectancy of 47 years, an infant mortality rate of 89 per 1,000 live births, an under-five mortality rate of 140 per 1,000 live births and a maternal mortality ratio of 857 per 100,000 births (SLDHS, 2008).The Country has a National Health Sector Strategic Plan (NHSSP) aimed at reducing inequalities and improve the health of the people of Sierra Leone, especially mothers and children, through strengthening National Health Systems to enhance health related outcomes and impact indicators. In line with this, the Government started implementing a Free Health Care policy for pregnant women, lactating mothers and children under the age of five years. While this has improved service uptake, it has also revealed certain health systems weaknesses. To help address these weaknesses the country has developed common management arrangement across the sector for all partners, covering procurement, disbursement and accounting of funds, planning and joint reviews of health sector performance in line with the Paris Declaration on Aid Effectiveness. A National COMPACT is now in implementation through a 3-year Joint Programme of Work and Funding (JPWF). In addition the Ministry has also developed a common national joint coordination mechanism that is fully aligned with the national health policy and strategic plan.  This proposal focuses on three health systems strengthening challenges. One of the challenges addressed in the proposal is strengthening the existing Facility and Maintenance Unit of the ministry by training and equipping staff to procure, install, maintenance and repair medical equipment. This is particularly important because a good proportion of health facilities in the country are poorly equipped. In addition a good number of the medical equipment including cold chain equipment in most facilities are inoperative and need repair. The Ministry however currently lacks a fully functional maintenance and repairs unit to maintain the equipment. With functional medical equipment maintenance system, the faulty refrigerators and solar systems will be quickly repaired and the negative effect on immunisation will be very short-lived. It is critical, therefore, that we develop our capacity to use and manage the available medical devices. With support from GAVI HSS, a batch of Equipment Maintenance staff at central and district levels will be trained, offices refurbished and equipped with tools and spare parts and mobility will be provided to make units fully functional.  The other Health Systems Challenge that is addressed in this proposal is the issue of getting health care to people in remote communities. This is important because about 25% of people live beyond 5km distance from the nearest health facility and distance to health facility has been cited as one of the barriers to utilisation of health services including immunisation. Outreach services which can help bring health care to people living in such communities is currently poorly and ineffective. This proposal therefore requests support from GAVI to revitalize out-reaches services through the Reach Every District (RED) approach. Health workers will be supported to get detailed information about their communities, planned out-reach and provide mobility to chiefdom teams for out-reach. Out-reach allowance will not be provided, because staff are already getting Performance Based Financing (PBF) as incentive to provide services to more people.  Finally, the proposal will also address the challenge of poor supply chain system for drugs, vaccines and other health commodities.With support from both Government and development partners, the sector currently benefits from a considerable quantity of drugs and other health commodities. However, the distribution of these drugs from Central to district stores and them to health facilities is seriously constrained by the almost total absence of vehicles to distribute the drugs and other items. With support from GAVI HSS, vehicles will be procured for both central and district level stores to help facilitate the distribution of the drugs and other health commodities. Cold chain equipments will be provided for vaccines and other items. This will contribute considerably in ensuring that vaccines and other health commodities reach health facilities in well-coordinated manner, thereby preventing stock-out of these items.  The Government is requesting the sum of **$ 5,399,371** for a period of three years 2012 – 2015 help address these three challenges. GAVI support is requested to fill in funding gaps in the implementation of 3-year JPWF, as all the activities in the proposal are from that plan. |

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| **Part B - Applicant Eligibility** |

If this application includes a request to the Global Fund, please fill outthe eligibility and other requirements section available [here](http://www.theglobalfund.org/en/application/materials/documents/#HSS).

If this application includes a request to GAVI, please click [here](http://www.gavialliance.org/support/apply/countries-eligible-for-support/)to verify the applicant’s eligibility for GAVI support.

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| **Part C - Proposal Details** |
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| **1. Process of developing the proposal** |
| * 1. Summary of the proposal development process   *→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.* |
| Following the release of the call for Round 11 Proposals by GAVI and Global fund on 15th August, 2011, the Health Sector Steering Group (HSSG) at its meeting on the 16th August 2011 agreed that the Ministry submits a proposal. The Information was then forwarded to the CCM. At another HSSG meeting it was agreed that the Directorate of Planning and Information (DPI) takes the lead in developing the proposal and puts a team together for the proposal development.  The DPI then sent an invitation to all health sector implementing partners and donors to attend a meeting to plan for the HSS proposal writing for both GAVI and Global fund. The Meeting was chaired by the Director Reproductive and Child Health Programme. At the meeting, a presentation was made by DPI on HSS strengthening, the objectives, the process and the type of interventions that have been supported in the past. The meeting was attending by Programme Managers and Directors in the MoHS, representatives of NGOs, UN Agencies, CSOs and Donor Partners. At that meeting it was agreed that we conduct a gap analysis of the HSS activities, in order to decide on the areas that the proposals should focus. A request was sent to all donors and implementing partners in the health sector to provide information on the activities they are implementing on HSS, the scope and lessons learnt. Very few responses were received. It was then proposed that as the sector was working on a Joint Programme of Work and Funding (JPWF), the proposal development team should take both the intervention and and financial gaps of HSS activities from the JPWF. During this period, we learnt that the Global fund has extended it submission date to 1st March 2012 and that GAVI has extend it submission date to 30th December 2011.  In October 2011, a request was submitted to the World Health Organisation for Technical Assistance to support the writing of the Global fund and GAVI proposals.  In October 2011, we received a draft of the JPWF, but without the cost. At a proposal development meeting in October, it was agreed that a GAVI HSS proposal should first be developed, as it will be submitted earlier than the Global fund proposal. At that meeting, miles stones for proposal developed were agreed.   1. Also at that meeting, based on information from the EPI programme Manager and the Sector Review report, it was agreed that the GAVI proposal be focused on strengthening out-reach, strengthening both facility and community IMNCI and strengthen equipment maintenance in the sector. Three teams were put together to write concept papers on the three components. The teams put together the concept notes, and these were submitted to DPI for compilation. 2. A draft proposal that was taken to Harare by a cross-section of the proposal writing team who attended the GAVI HSS Proposal peer review meeting. The draft proposal was reviewed and summary of the proposal content was again presented to the HSSG meeting of 6 December 2011. The HSSG were informed of the decision by Global fund to suspend HSS proposal submission till 2014. The HSSG then suggested that proposal be revised to include aspects of supply chain management, as it was a critical challenge in the sector. They also agreed that the proposal be submitted on the later date of March 31, 2012. 3. The proposal was reviewed prioritising supply chain management, outreach using the RED approach and facility and equipment maintenance. 4. The revised proposal was circulated for all stakeholders for final comments and input. After which it was then circulated to all HSSG member for final comments before submission. |
| 1.2 Summary of the decision-making process  *→ Please summarise how key decisions were reached for the proposal development.* |
| Several decisions were made on the GAVI proposal submission.  The First Decision was that Sierra Leone would submit a proposal in response to Round 11. That decision was made by both HSSG and also by the CCM in August 2011. The Planning department was identified to lead the proposal writing process, as they have been writing previous HSS proposals. Both the CCM and the HSSG are existing and functional committees in the sector. The HSSG has an approved TOR and includes representatives of all stakeholders in the health sector, namely, government departments (Local Government and Ministry of Finance), Donors, NGOs, CBO, FBOs and CSOs. The CBOs represent marginalised group on the Committee.  The Second decision was on the areas that the proposal should address. This decision was made at a meeting of stakeholders that was convened by the Planning Department and attended by other MoHS staff, UN Partners, CSOs and NGOs. At that meeting an analysis was made of the barriers to immunisation, using information from the cMYP, National Health sector Review report and the NHSSP. At that meeting three areas were identified for inclusion in the GAVI HSS proposal. These were: Outreach, rolling out IMNCI at both community and facility levels to address immunisation and malnutrition and addressing the poor condition of medical equipments in the country. Teams were identified to prepare concept notes on each of the areas.  With the suspension of the Global fund HSS proposal submission, which initially was earmarked to address Procurement and Supply Chain, HSSG made the decision to include PSM in the GAVI Submission. They also made a decision to defer the proposal submission date to March 2012.  The final decision was approval by the HSSG of the proposal and its budget for submission to GAVI HSS. |

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| **2. National Health System Context** |
| * 1. a) National Health Sector   *→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.*   * 1. b) National Health Strategy or Plan   *→ Please highlight the goals and objectives of the National Health Strategy or Plan.*  2.1 c) Health Systems Strengthening Policies and Strategies  → Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems,health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.) |
| **2.1. a) National Health Sector**  Sierra Leone has some of the poorest health indicators in the world, with life expectancy of 47 years, an infant mortality rate of 89 per 1,000 live births, an under-five mortality rate of 140 per 1,000 live births and a maternal mortality ratio of 857 per 100,000 births (SLDHS, 2008). The country suffers from diseases, including, malaria, tuberculosis, acute respiratory diseases, and diarrhea for which cost-effective interventions are available. Fertility rates are high due to low contraceptive utilization and malnutrition is widely spread among children and lactating mothers. Non-communicable diseases like diabetes, cancers and cardio-vascular diseases are beginning to assume significance, accounting for a considerable proportion of deaths among the adult population (MOHS 2011a).  Access, quality, equity and the utilization of Primary Health Care (PHC) services are still low and there is considerable room for improving their effectiveness and efficiency. According to the 2010 health sector performance report, the percentage of children fully immunized increased from 64% in 2009 to 75% in 2010 (MoHS 2011b). These figures are moderate and reasons for not vaccinating include lack of knowledge and distance to the health centre (MoHS 2011)  According to data from the Health Management Information Systems of the MoHS, malaria accounted for about 50% of all underfives consultations in 2010, followed by Respiratory infections (23.5%), worm infestation (4.5%), diarrhea (4%) and clinical malnutrition (3.8%). These conditions are all preventable with cost –effective interventions (MoHS 2011a).  The major causes of underfives death in hospitals are malaria (41%), respiratory tract infections (17%), anemia (12%) and diarrhea (5%). With effective case management these conditions can all be treated and the deaths could be averted.  Children in Sierra Leone are generally malnourished. Data from successive household surveys conducted over the years show that the malnutrition among children has reduced 31.9% in 2005 to 18.7% in 2010 (UNICEF 2005, MoHS, 2010a). Though these figures show tremendous improvement in nutritional status of the children, the level of malnutrition among children is still high and a cause for concern, as poor nutrition can precipitate a variety of ill-health conditions. Preventive interventions such as the distribution of Vitamin A supplementation and exclusive breastfeeding in the first 6 months of life are among the best proven, safest and cost effective interventions in public health. In 2010, about 383,964 doses of vitamin A supplementation was provided to children (MoHS 2011a). This however compares unfavourably with the estimate number of 2 million doses (2 doses per year for all children under five) that should have been given.  Fertility rates are high, estimated at 5.1 for women for 2008. High fertility rates are closely related to rural residence and low socio-economic status, with age at first childbirth being low. Contraceptive prevalence rate though still low has increased from 5% in 2005 through 8% in 2008 to 13% in 2010. (UNICEF 2005, SSL, 2008, MoHS (2010).  Availability of clean water and safe sanitation is a major factor affecting the health status of the population. More than one third of the population still does not have access to safe drinking water, and two thirds do not have access to improved sanitation facilities (MoHS 2010b). Inadequate multi sectoral coordination is one of the main obstacles to promoting equitable access to safe water and sanitation.  As part of a broader administrative reform of the state in 2004 (Local Government Act), all health service delivery was decentralized to local councils run by elected Majors and Local Council Chairmen. The central level MOHS was left in charge of policy/planning, regulation, training, national health programs, and procurement of essential drugs. Primary and Secondary Health care are under the direct control of the Local Councils and these receive funds through the Councils. The Local Councils receive their funds directly from the Ministry of Finance and Economic Development.  Health services delivery is pluralistic. There are public, private for profit, private non-profit and traditional practice. There are a total of 1268 health facilities in the Country, of which 1,105 (87%) are public and 163 (13%) are ether private for profit or private not-for-profit.  The District Health Service forms the core component of the primary health care. It is comprised of a network of peripheral health units (PHUs), the district hospital and the District Health Management Teams (DHMT). The PHUs are the first line health services and are further sub classified into three levels, namely, Maternal and Child Health Post (MCHP), Community Health Post (CHP) and Community Health Centres (CHC) (MoHS, 2005).  The Maternal and Child Health Posts (MCHPs) are at village level for population of less than 5,000 and staffed by Maternal and Child Health (MCH) Aides and supported by community health volunteers and Trained Traditional Birth Attendants (TBAs). MCHPs provide antenatal care services, supervised deliveries, postnatal care, family planning, growth monitoring and promotion for under five children, immunization, health education, management of minor ailments and referral of cases to the next higher level.  Community Health Posts (CHPs) are at small town level with the population of 5,000 - 10,000 and are staffed by Community Health Nurses, Community Health Assistants (CHAs) and MCH Aides. They provide same type of services as MCHPs, but also include prevention and control of communicable diseases and rehabilitation.  CHPs refer cases to the Community Health Centers (CHCs) which are located at chiefdom head quarter towns, usually covering a population of 10,000-20,000 and staffed with a Community Health Officer (CHO), Community Health Nurse, MCH Aides, Endemic Disease Control Unit (EDCU) Assistants and Environmental Health Officers (EHOs). They provide all the services provided at the CHP level but also add environmental sanitation and supervise the CHPs and MCHPs within the Chiefdom.  The district hospital is a secondary level facility providing backstopping for the PHUs. It provides the following services: outpatient services for referral cases from PHUs and the population living within its immediate environment, inpatient services, and diagnostic services, management of accidents and emergencies, technical support to PHUs.  Total government expenditure on health increased from Le 61.5 billion in 2009 to Le 91.7 billion in 2010. Donor support accounts for the bulk of the public health spending. Government expenditure on health increased from 8% in 2009 to 12% in 2010 and then to 11% in 2011 of government recurrent expenditure.  The Government’s relationship with Civil Society organisations (CSOs) has improved greatly over the past two years and particularly so during the implementation of the Free Health Care Policy. CSOs working at community level have been empowered to provide an independent report on the level implementation of Free Health Care policy, client satisfaction, and community perception towards free health care and to bring to light allegations of corruption in delivering the services e.g. clinic staff charging for services that are meant to be free and misappropriation of drugs and other health commodities. Representatives of CSOs have been located in each of the 149 chiefdoms to conduct regular monitoring of health facilities. CSOs have as part of their Terms of Reference the establishment of facility management committees for each health facility and to support them to function well. Despite these aforementioned progress the sector still continue to face challenges.  **2.1 b) National Health Strategy or Plan**  The Goal of the National Health Sector Strategic Plan (NHSSP) is to reduce inequalities and improve the health of the people, especially mothers and children, through strengthening national health systems to enhance health related outcomes and impact indicators.  This goal translates the overall mission and vision of the National Health Policy into policy objectives that are in line with the “Agenda for Change”, the Ouagadougou Declaration and the MDGs.  The **general objective** is to strengthen the functions of the health system of Sierra Leone so as to improve the following performance criteria:  1. Access to health services (availability, utilization and timeliness)  2. Quality of health services (safety, efficacy and integration)  3. Equity in health services (disadvantaged groups)  4. Efficiency of service delivery (value for resources)  5. Inclusiveness (partnerships)  The Strategic plan was developed through a consultative process including Civil Society Organisations, NGOs and all stakeholders in the health sector. These were included in agreeing that the Health Sector Strategic plan be focused on improving the health system as a whole using reproductive and child health as the vehicle. CSOs were part of the stakeholders invited to the various consultative meetings that were held in the process of developing the plan.  The first two years implementation of the NHSSP was based on Annual Operation plans developed by Local Councils at District level and Programmes and Directorates at National level. The Partners have however recently agreed that the NHSSP should be implemented through a Joint Programme of Work and Funding (JPWF), which is a Medium Term Expenditure Framework (MTEF) to address the policy objectives of the NHSSP in the medium term. It is a 3-year rolling operational plan (2012 – 2014) for the health sector and provides the basis for development of AOPs that guide the implementation of sector activities.  **2.1. c) Health Systems Strengthening Policies or Strategies**  The National Health Policy is based on the principles and concept of Primary Health Care. The implementation of the policy is facilitated by a number of technical policies as outlined below.  The National Health Sector Strategic Plan (NHSSP) was developed around strengthening of six key pillars of the health system, namely: (1) leadership and governance, (2) service delivery, (3) human resources for health, (4) medical products and technologies, (5) healthcare financing, and (6) health information systems. These priorities are to improve infant and maternal health with the aim of progressively moving towards universal coverage, reducing the burden of communicable and non-communicable diseases and improving the quality of services provided by retaining highly qualified and motivated staff that work in an enabling environment.  In tandem with the formulation of this strategic plan, the sector has developed a ‘Basic Package of Essential Health Services for primary health care and hospitals’.  There are other policy including: Draft Human Resources Policy, which focuses on training of health staff, Planning of Human Resource needs, well-managed and professional staff for health; National Medicines Policy which focuses on improving availability of high quality and efficacious medicines, ensuring that relevant structures are in place overseeing the pharmaceutical supply and distribution; Monitoring and Evaluation Strategic plan which focus on providing timely, accurate and complete data for decision making. The Ministry has also recently developed a Compact. The COMPACT is a negotiated and signed, time-bound, voluntary agreement between the Government of Sierra Leone and its health development partners in which both commit to mutual responsibility and accountability for the development and implementation of a robust results-oriented health plan and strategy- JPWF that tackles health system constraints. |
| 2.2 Key Health Systems Constraints  *→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).* |
| Sierra Leone like other African countries is confronted by a heavy burden of communicable and non-communicable diseases. Cost-effective interventions that can prevent the disease burden exist but their coverages are low due to health systems weaknesses. These weaknesses can be described under the 6 health systems pillars of 1. Leadership and Governance, 2. Human Resources for Health, 3. Medical technologies and Products, 4. Health Information systems, 5. Health Financing and 6. Service delivery.  In the area of Leadership and Governance, the weaknesses are: inadequate health-related legislations and their enforcement resulting in weak mechanism for monitoring services provided in the sector; weak public private partnership (PPP) in the provision of comprehensive integrated health services; limited community participation in planning; weaknesses in the management and monitoring of health services and; horizontal and vertical inequities in health systems.  In the area of Human Resources for Health, Sierra Leone has a critical shortage of skilled health staff, thus compromising the quality of care provided. The crisis has been exacerbated by inequities in workforce distribution and brain drain. Thus, the delivery of effective public health interventions to people in need is compromised particularly in remote rural areas. Existence of appropriately trained human resources is an important pre-requisite for the delivery of the BPEHS in Sierra Leone. Sierra Leone, however, is experiencing a major crisis in responding to the heavy disease burden which, due to staff shortages ranging from 40 to 100% of required staff, in spite of a current strength of 8,300 health workers.added figures*.* For example, there is only one staff with expertise in equipment maintenance.  In the area of Medical technologies and products, access to health services is limited by frequent reports of stockout of essential medicines and other health commodities, mainly as a result of weak supply chain management system. The inadequate logistical support for the supply and distribution of drugs and other medical supplies from Central to District stores and to health facilities, coupled with the unavailability of trained and qualified personnel to carryout immunisation activities poses tremendous problems.  In the area of Health Information System, Sierra Leone health Information Systems is fraught by weak capacity for data analysis, reporting, dissemination and use, weak hospital information and vital registration systems, poor engagement of the private sector and community groups in data collection, lack of feedback at all levels, poorly defined catchment area population as well as the non-existence of a maintenance plan for existing ICT infrastructure both at national and district. There is also a weak information, communications technology (ICT) and mass Internet connectivity, compounded by a paucity of ICT-related knowledge and skills limiting capacities of national health management information systems (HMIS) to generate, analyze and disseminate information for use in decision-making.  Health financing in the Sierra Leone is characterized by low investment in health, lack of comprehensive health financing policies and strategic plans, extensive out-of-pocket payments, lack of social safety nets to protect the poor. Government expenditure on health is of particular importance as the public health services in Sierra Leone are the major source of health care for a large proportion of people (70%) who are living below the poverty line and rural areas which are not serviced by the private sector. Per capita government expenditure on health for Sierra Leone was US$9.05 in 2004, US$11.76 in 2005 and US$12.16 in 2006 which is however not commensurate with the WHO Commission for Macroeconomics and Health (CMH) recommendation that governments spend at least US$34 per person per year on health. As a result most planned activities are not implemented.  Finally, in terms of service delivery, existing functional health facilities are inadequate and inequitably distributed nationally thus prompting the Ministry to increase the number of health facilities in order to bring them closer to the beneficiaries. This tends to over-stretch the limited resources in the health sector, resulting in poorly equipped health facilities. There is also the poor involvement of communities in the implementation of health activities, creating the situation where-in myths and misconceptions flourish and community members continue seeking services from traditional healers and avoiding modern medicines. Most facilities do not conduct out-reach services. In addition to the above most equipment in the health facilities including cold chain equipment, are non-functional due to lack of equipment maintenance. Even though, the ministry of health and sanitation has a facility and maintenance unit, the staff lacks capacity (technical and logistic) to function effectively. |
| 2.3 Current HSS Efforts  *→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.* |
| In order to further accelerate progress towards meeting the MDGs and other strategic targets, the Government and partners are implementing a series of health systems strengthening activities in all 6 pillars of the National Health Sector Strategic Plan.  Under the Governance Pillar, the sector has developed common management arrangement across the sector for all partners, covering procurement, disbursement and accounting of funds, planning and joint reviews of health sector performance in line with the Paris Declaration on Aid Effectiveness. A National Compact is now in implementation through a 3-year Joint Programme of Work and Funding. In addition the Ministry has also spearheaded the process of developing a common national joint coordination mechanism that is fully aligned with the national health policy and strategic plan. There is the Health Sector Coordinating Committee (HSCC), the highest decision making structure in the sector, comprising Government Ministers, Development Partners, Civil Society Organisations (CSOs) and Non-Governmental Organisations (NGOs). Under the HSCC there is the Health Sector Steering Group (HSSG) and its thematic sub-committees that meet on regular basis. These activities have been supported partly by WHO.  Under the Service Delivery Pillar, the following HSS Activities are currently on-going; with support from ADB, through the SDHSP, the Ministry is expanding 15 health facilities to serve as centres of BEMONC services in 5 districts. The Ministry has also developed a strategy for community health workers. These will be volunteers based in communities to provide health education and provide emergency treatment for malaria, ARI and Diarrhoea. A manual has also been developed for the training of community health workers. UNICEF is piloting the use of community health workers to provide basic health care services in two districts.  The Ministry is also strengthening the national laboratory services. With support from WHO a National laboratory services policy and strategic plan has been developed and disseminated. Global Fund HSS Round 9 is supporting the following: training of laboratories staff in basic laboratory procedures, postgraduate training for 7 laboratory staff in the sub-region, procurement of laboratory equipment and consumables for hospitals and PHUs, equipping the National reference laboratory to diagnose epidemic conditions like yellow fever, polio etc.  Under the Drugs and Medical technology pillar, the Ministry has as part of strengthening the procurement and supply chain management system, constructed larger storage facilities at the Central medical Stores, district medical stores and improved PHU storage facilities. They have trained drug store keepers and health workers in proper inventory and control management. Electronic Logistics management information system is being established to capture drug information at both district and national level. DFID, UNICEF and UNFPA have supported these activities.  The Government has endorsed an Act permitting the establishment of a National Pharmaceutical Procurement Unit (NPPU), which will buy all essential drugs for the public health sector. The creation of the NPPU will help considerably to streamline procedure for the procurement, storage and distribution of drugs and medical supplies. With the right technical staff and seed money, the system will ensure a continuous stock of drugs, equipment and other consumables for health facilities. This system will ensure readily available essential drugs and medical supplies in the country. An MOU for a firm to perform these functions has been developed and ready for submission to parliament for endorsement.  The Ministry is also strengthening its blood services functions by establishing a blood bank in each of the 13 districts by 2015 through upgrading and construction where necessary. Besides the procurement of drugs, the Ministry is strengthening its health facilities by procuring consumables and medical equipment for health facilities. The Ministry is working towards having at least two health workers per facility.  Under the Health Care Financing Pillar, the Government is implementing a Free Health Care Policy, whereby free health care services are provides to pregnant women, lactating mothers and children under the age of five. With support from International Labour Organisation (ILO), the Ministry has conducted a feasibility study for the implementation of a National Health Insurance Scheme. Plans have been made to start its implementation in two districts, as a pilot, and then gradually roll it to other parts of the country.  The Ministry has started the implementation of a national performance based financing (PBF). PBF has been identified in the National Health sector Strategic plan as one of the strategies for improving health services quality. With support from the WB, the PBF is now implemented in over 1,200 health facilities in the country. It is expected that this will be extended to hospitals when additional funding is secured. The PBF, focus on quantitative and qualitative indicators, which forms the basis of cash transfers to facilities.  The Ministry is also in the process of improving its financing management system. The Integrated Financial Management Information System (IFMIS) is now fully functional in the Ministry to capture public health expenditure. This system is being expanded to also capture donor contribution to the health system.  Under the Human Resources Pillar, the Government has recently increased the salaries of health workers bringing them in line with salaries of health workers in the sub-region. This has been possible with support from Government, DFID and Global fund, who are committed to supporting salaries for a period of fives years ending 2015. The Global fund is also supporting the provision of remote allowances as incentives for health workers in rural communities. This is also expected to continue till 2015. The DFID funded Rebuild research programme is also planning to commission research into rural incentives to ensure MoHS planning is further backed by key evidence of the next 2-3 years.  The WHO is supporting the development of a Policy for Human Resources for Health, as well as a strategic plan. The Ministry has also developed a Training plan and post-basic training programmes for the Health sector.  ADB through the Strengthening District Health Services Project (SDHSP) is providing support to train staff in five districts in basic surgery, safe motherhood, master in reproductive health and disease control and nutrition. The Voluntary Services Overseas (VSO) is supporting the Sierra Leone Health Sector with trained medical staff from other countries to work for varied periods in Sierra Leone. Global Fund through the HSS Round 9 project is supporting Post-graduate training of staff in laboratory diagnosis and Health Information systems. The World Bank is also supporting expert tutors to teach critical medical courses in Sierra Leone. The best of the trainees will then become trainers for subsequent trainings. DFID is supporting MoHS through OPTIONS to strengthen MOHS on agreed priorities and targets specifically across RCH, HR, Finance and support to the Compact, JPWF and coordination efforts centrally and within districts and strengthening Civil Society organizations to monitor FHC.  To ensure that all health workers benefit from training opportunities, a system of on-the-job training, mentoring and skills development has been introduced, whereby staff with more technical skills provides coaching to lower level staff during integrated supportive supervision.  The Government and Partners are procuring additional medical equipment for PHUs and hospitals. The Government and UNICEF are supporting the maintenance and construction of cold-chain systems in the country. A Kuwaiti Government –supported project is renovating and equipping 3 tertiary hospitals that will serve as centers of excellence for post-graduate training.  Under the Health Information Systems pillar, the World Bank is providing support for supportive supervision by central level staff to districts, the revitalization of the Health Information System and the development of integrated data warehouse (IDW). The Global fund is supporting training of Monitoring and Evaluation officers in data analysis and use of the IDW and post-graduate training of 3 candidates in the sub-region in Health Information System. The WHO is supporting the establishment of an integrated HRH information system as part of the HMIS whereby health managers at appropriate levels keep their HR inventory up-dated and maintained. OPTIONS is supporting the Facilities Infrastructure Team quarterly monitoring visits to assess functionality and Progress towards key targets to upgrade selected BEmONCs and CEmONCS in all Districts. |

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| **3. Health Systems Strengthening Objectives** |
| * 1. HSS objectives addressed in this proposal   *→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.* |
| Three different HSS objectives have been considered in this proposal, all selected from the National health Sector Strategic Plan.  Objective 1: To restore health care services and enhancing the quality of and sustainability of health interventions by strengthening the medical equipment management and maintenance system as an integral part of health service delivery.  Objective 2: To increase the utilization of health services especially for mothers and children, the poor and other vulnerable groups from 0.5 contacts per person per year to at least 3 contacts per person per year by 2015.  Objective 3: To improve access to good quality, efficacious, safe and affordable medicines, medical supplies and equipment, vaccines and health technologies  Objective 1 will focus on strengthening the existing Facility and Maintenance Unit of the ministry by training and equipping staff to procure, install, maintenance and repair medical equipment. This is particularly important because a good proportion of medical equipment in health need regular maintenance and repair system. According to a recent Health Facility survey report most of the health facilities are poorly equipped. Data from the HMIS shows that more than 50% of the equipment in most facilities are inoperative. Heat, humidity, inadequately trained operators, erratic electrical current and insect and animal attacks on this equipment all contribute to their premature demise. It is prohibitively expensive to ship these equipment to Europe or the United States for repair. This is particularly critical for immunisation because cold chain systems for maintaining the temperature at which vaccines are stored do breakdown regularly. A recent assessment of the cold chain system in the country showed that there are adequate cold chain equipment in the country to support EPI, however most of the equipment are non-functional. Although every district has two trained solar refrigerator technicians, currently, a good number of health facilities have broken-down refrigerators or freezers as a result of inadequate spare parts, lack of district system for preventive maintenance and high attrition of the trained technicians. In the absence of any maintenance scheme in the system, these refrigerators and freezers will remain in a non-functional state for a long period of time. Without a vaccine storage system, staff in these facilities store their vaccines in neighbouring facilities with functional refrigerators, and often these facilities are several miles away. Whenever these staff want to use the vaccine, they must go in the morning to pick up their vaccine, bring them to their facility and use them. Left –over vaccines are also returned to the facility on the same day. This causes a lot of strain and often does not motivate staff to conduct regular immunisation and go on out-reach visits. This leads to a lot of missed opportunities for vaccination, thus resulting in low immunisation coverage. The lack of a functional maintenance and repairs system has far-reaching implications for health care delivery and represents a deplorable waste of scarce resources. With functional medical equipment maintenance system, the faulty refrigerators and solar systems will be quickly repaired and the effect on immunisation will be very short-lived. It is critical, therefore, that we develop our capacity to use and manage the available medical devices.  Objective 2 will focus on strengthening implementation of the (Reach Every District) RED strategy in all districts of the country. The strategy has five components as follows   * Planning and Management of resources * Reaching the target populations * Linking services with the community * Monitoring for action * Supportive supervision   National level teams will support districts health management teams to conducts thorough sub-district micro-planning in their respective districts. Information generated from this process will be utilized in developing implementation plans which will be subsequently used for resource mobilization.  In a bid to enhance effective implementation of the RED strategy in Sierra Leone, the RED documents have already been adapted to the national context. It is envisaged that the RED strategy, which is designed to improve immunization coverage, can also be used as a good vehicle to deliver integrated reproductive and child health services through Facility- IMNCI, Community-IMNCI and outreach services. When fully implemented, the health related MDGs will be within achievable reach.  Conducting out-reach activities will bring health care services closed to remote communities. About 25% of people live beyond 5km distance from the nearest health facility and distance to health facility has been cited as one of the barriers to utilisation of health services including immunisation. Outreach services have been used to bring health care to people living in such communities. Mobile and outreach services that provide a package of proven cost effective interventions like Immunization, ITNs, family planning, Vitamin A supplements, de-worming drugs, nutritional counselling, antenatal care and treatment of common illnesses will take essential health care closer to communities that do not have ready access. Lesson learnt from providing immunisation services shows that when staff conduct out-reach services the up-take increases and the drop-out rate reduces. Available statistics reveals that the EPI coverage has been plummeting since the introduction of the Free Health Care. With the current inter-facility distance of 3-5 mile radius between functional health facilities, a sizeable population of women and children can only be accessed through the outreach services. However, unfortunately, outreach services have plummeted over the years due to a multitude of factors, thereby depriving thousands of women and children from enjoying quality health care services provided to enhance their welfare. These factors include:   * Long distances on foot * Inadequate health logistics * Poor transport facilities * Low staff morale   Outreach service delivery constitutes a major strategy in accessing women and children with live saving vaccines. The strategy has been used successfully in countries with similar context and challenges to increase coverage for immunisation and other evidence based, high impact and cost effective interventions.  Objective 3 will focus on addressing the challenge of poor supply chain system for drugs, vaccines and other health commodities. With support from both Government and development partners, the sector currently benefits from a considerable quantity of drugs and other health commodities. However, the distribution of these drugs from Central to district stores and them to health facilities is seriously constrained by the almost total absence of vehicles to distribute the drugs and other items. Vehicles will be procured for both central and district level stores to help facilitate the distribution of the drugs and preventive maintenance. Cold chain equipments and spare parts will be provided for vaccines and other items. This will contribute considerably in ensuring that vaccines and other health commodities reach health facilities in well-coordinated manner, thereby preventing stock-out of these items. |
| * 1. a) Narrative description of programmatic activities   → Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.   * 1. b) Logframe   *→ Please present a logframe for this proposal as Attachment 2.*   * 1. c) Evidence base and/or lessons learned   *→ Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide details of previous experience of implementing similar activities where available.* |
| **Goal:** The Goal of this proposal is to reduce inequalities and improve the health of the people, especially mothers and children, through strengthening national health systems to enhance health related outcomes and impact indicators.  **Objective 1.0** To restore health care services and enhancing the quality of and sustainability of health interventions by strengthening the medical equipment management and maintenance system as an integral part of health service delivery.  **SDA 1.1: Human resources: skills building for service delivery, advocacy and leadership**  **Description of Activities**  This proposal therefore seeks to train medical equipment maintenance staff and to equip the unit with the necessary equipment for repair of medical equipment. Specific activities to be undertaken include:  Activity 1.1.1: Recruit and train 30 health care technology personnel in equipment maintenance  Activity 1.1.2: Conduct physical rehabilitation of 13 district facility and maintenance units and equip them with maintenance tools, informatics etc. needed for proper operations.  Activity 1.1.3: Procure spare parts,  Activity 1.1.4 Provision of mobility for national and district level facility maintenance staff.  Activity 1.1.5. Conduct inventory of medical equipment in the Sector and design a data-base for managing inventory and aiding in-charges/DMOs/ managers in their maintenance, repair and/ or procurement decisions.  ***Activity 1.1.1: Recruit and train 30 health care technology personnel in equipment maintenance.***  Thirty (30) trained and qualified personnel with at least diplomat/certificate in engineering, carpentry, masonry, electrical or engineering will be recruited from the general public. These will be paid by Government according to their qualification in accordance with the government civil service salary scale. The thirty (30) medical equipment technicians will be trained in repair of equipment at national level. Special tailored courses will be provided for them in the engineering department of the University of Sierra Leone. These will be trained for about 3 months, in the installation of medical equipment, repair of equipment and provision of preventive maintenance for equipment. The staff at central level will provide technical backstopping to the staff at district level. A consultant will be recruited to work with the Facility Maintenance Unit at Central level to support the training for the equipment technicians. The consultant will be recruited for a period of 12 months, during which he will install, repair critical equipments as well as provide on-the-job training for national and district level technicians. Four staff of the Medical Management unit at central level will be given additional training in the sub-region in bio-medical technology. These staff will be trained to both install maintenance and repair various medical equipments.  ***Activity 1.1.2: Conduct physical rehabilitation of 4 regional facility and maintenance units and furnish them with test equipments, maintenance tools, informatics etc. needed for proper operations***  Medical equipment repairers use a wide variety of tools to conduct their work, including hand tools, soldering irons, and other electronic tools to fix or adjust malfunctioning equipment, such as a broken wheelchair. If a machine is not functioning to its potential, the repairer may have to adjust the mechanical or hydraulic components, or adjust the software to bring the equipment back into calibration. Fifteen (15) sets of basic equipment maintenance tool kits will be procured for 13 district teams and 2 central level maintenance units. Thirty repair kits will be provided for individual technicians.  **Activity 1.1.3: Procure spare parts:**  Assorted spare parts will be procured after a thorough assessment of all medical equipment in the sector has been conducted. Therefore a lump sum of US$150,000 will be budgeted for procurement of assorted range of spare parts, per year.  ***Activity 1.1.4 Provision of mobility for district level facility maintenance staff.***  The central level team will be provided with 2 vehicle and 2 motorbikes, while each district team will be provided one motorbike. The one motor bike at district level will be to facilitate movement within the district for the facility management unit staff. The purpose of these vehicles and bikes will be to visits individual health facilities and repair their equipments. Fuel will also be provided for to support movement of staff to health facilities.  ***Activity 1.1.5. Conduct inventory of medical equipment in the Sector and design a data-base for managing inventory and aiding in-charges/DMOs/ managers in their maintenance, repair and/ or procurement decisions***  A consultant will be recruited to conduct an inventory of all equipment in the health facilities as well as determine what is working and what is not working. The Consultant will develop a tool, and a team of enumerators to collect information at health facilities will use the tool. A team of 30 data collectors will do data collection for a period of 30 days. The information will be stored in a database that will be specifically designed to capture information of equipment. Information captured will include detailed location, specification of the equipment, year of purchase, functionality and periodicity of it s preventive maintenance. The information in the system will be set up at district level where it will updated periodically by Facility Maintenance Technicians and sent to national level, where it will be compiled.  **Objective 2:0 To increase the utilization of health services especially for mothers and children, the poor and other vulnerable groups from 0.5 contacts per person per year to at least 3 contacts per person per year by 2015.**  **SDA 2.1 CSS: Community based activities and services - delivery, use and quality**  Activity 2.1.1: Conduct comprehensive census of existing health facilities and their outreach communities  Activity 2.1.2 Training of health staff in all districts on RED strategy  Activity 2.1.3 Conduct detailed facility based micro-planning in all districts.  Activity 2.1.4 Provide mobility for outreach activities  Activity 2.1.5 Conduct periodic supportive supervision in all districts  **Description of activities**  **Activity 2.1.1: Conduct comprehensive census of existing health facilities and their outreach communities**  The aim of this activity is to collect information on the catchment communities and their population for all the facilities in all districts. A tool will be developed to collect the data and 2 x 1200 PHU staff will be provided 1-day orientation in the use of the tool. For each facility, information will be collected on distance of each surrounding settlement, their population (disaggregated by sex and age), means of transportation, and existence of a village development committee and community health worker. The information will be sent to district level and collated in a database and information for individual facilities sent back to them. Each PHU will be given printed data collection tools, pencils, plastic folders and 2 days per-diem for the exercise.  **Activity 2.1.2 Training of health staff in all districts on RED strategy**  The Reaching Every district (RED) Strategy has been identified as a key strategy for increasing service coverage using the Integrated approach. The Standard RED training manual has already been adapted for Sierra Leone. This will used to provide Training of Trainers for 65 DHMTs member and 25 National Supervisors in the use of the adapted training manual. These will serve as trainers for PHU-in-charges in their respective districts. A total of 1,200 PHU staff (at least one from each PHU) will be trained in the RED Approach for 1 day.  **Activity 2.1.3; Conduct detailed facility based micro-planning in all districts.**  Chiefdom level micro-planning exercises will be conducted. Teams for micro planning will include in-charges from all health facilities in the chiefdom, two community health workers, district level supervisor and a national facilitator. The micro-planning will take place for a period of 1 day and the standard WHO micro-planning tool, adapted for Sierra Leone will be used for each facility. At the end of the exercise a detailed micro-plan will be developed for effective service delivery, for each health facility, that will be used to increase coverage.  **Activity 2.1.4 Provide mobility for outreach activities**  Transportation will be provided to support movement for the network of PHUs in each chiefdom. One motorbike will be provided for each chiefdom to facilitate movement. These will be based at Chiefdom level. These motor-bikes will be used to transport staff to out-reach centres, transport vaccines and other commodities from CHC to surrounding PHUs and transport commodities to community health workers. A total of 170 motor bikes will be procured for health workers.  Facilities will use the investment portion of their Performance Based financing incentives to provide fuel and contribute to the maintenance of the motor-bikes.  **Activity 2.1.5 Conduct periodic supportive supervision in all districts**  Vehicles will also be provided for each district and National Supervision team. Each district will be provided 1 vehicle for supervision and national supervision teams will be provided 5 vehicles. Joint Integrated Supportive Supervision will be conducted at both district and national levels. According to the national supervision guidelines, each DHMT should supervise all facilities with the district each quarter. National teams should supervise all DHMTs and at least 5% of PHUs each quarter. DSA, fuel and stationary will be provided for these supervision visits. At district level, 1,000 litres of fuel will be provided for supervision for the quarter and DSA for a team for 3 persons for 5 days and stationery (Paper and ink). For National level supervision, 5 National level Supervisory teams, comprising 3 persons per team will be constituted for district level supervision. Each national level teams will be provided DSA for 5 days, 1000 litres of fuel and stationery (Paper and ink).  **Objective 3.0: To improve access to good quality, efficacious, safe and affordable medicines, medical supplies and equipment, vaccines and health technologies**  SDA 3.1 HSS: Procurement and Supply chain Management  **Activities**  Activity3.1.1: Procure Trucks for Distribution of drugs and vaccines from Central to District levels  Activity3.1.2: Procure 4-wheel drive vehicles for distribution of drugs and vaccines from District to Facility level.  Activity 3.1.3: Procure cold chain refrigerators and cold boxes for storage of vaccines  Activity3.1.4; Procure boats for distribution of drugs in riverine areas.  Activity3.1.5: Expansion of existing districts medical stores and national cold room  **Description of Activities**  **Activity 3.1.1: Procure Trucks for Distribution of drugs and vaccines from Central to District levels**  Two additional haulage trucks with two refrigerated truck will be procured for the distribution of drugs, medical supplies, and vaccines for Central Store. These trucks will be located at the central medical store and will be used only for distribution of drugs, vaccines and other health commodities to district level.  **Activity 3.1.2: Procure 4-wheel drive vehicles for distribution of drugs and vaccines from District to Facility level.**  A total of 14 covered 4-wheel drive vans will be procured, for the distribution of drugs, vaccines and other health commodities to the health facility. Each district will be provided one vehicle to facilitate the distribution. Western Area will be provided 1 extra vehicle to cover both rural and urban facilities. These vehicles will be covered to protect the drugs and other health commodities from damage by rain and dust.  **Activity 3.1.3: Procure cold chain refrigerators and cold boxes for storage of vaccines**  Currently 776 of the 1,200 PHUs are equipped with solar powered refrigerators that provide cold chain for vaccines storage. This proposal aims at providing 240 additional facilities with solar powered refrigerators, with the view of reducing fast cold chain means of storage. 2,200 cold boxes will also be procured to cover needs for new and existing PHUs.  **Activity 3.1.4: Procure boats for distribution of drugs in riverine areas.**  Three fibre-glass speed boat, each with a 50-horsepower engine will be procured for the distribution of drug and vaccines to riverine districts – Bonthe, Moyamba and Kambia.  **Activity 3.1.5: Expansion of existing district medical stores and national cold room**  Four district stores (those located in regional head quarter towns) will be expanded to serve as regional stores. The national cold room will also be expanded to provide additional storage space. 400 additional refrigerators will be procured for both national and district cold rooms.  *Evidence base and/or lessons learned*  *Objective 1.* Prior to the out-break of civil war in Sierra Leone, in 1991, there were functional facility maintenance units at Central and at district levels, equipped with qualified staff and tools. These staff were carrying out routine maintenance of medical equipment and vehicles, as a result the equipments were longer-lasting and facilities were adequately equipped. However, during the 11-year civil war, the system collapsed and the units were vandalised. This has resulted to state where most equipment including vehicles are non-functional because of lack of routine maintenance.  *Objective 2*. Health facility censuses are conducted periodically in Sierra Leone to collect information used for annual planning which is a sartorial norm. In addition, surveys (MICS and DHS) are conducted every three to five years as an objective means of collecting information on health indicators. Subsequent to several years of implementation of censuses for the health sector, it has become clear that without an integrated data harmonisation mechanism, different agencies have been using different estimates for the same entities within a given period. As a resolve to ameliorate this problem, the MOHS has now developed an integrated HMIS, in collaboration with partners. Generic tools for RED and IMCNI have been adapted for the Sierra Leonean context and implementation commenced with available funding. This proposal will further complement efforts of the GOSL and other partners to move this process forward. So far, with funding secured from partners such as ADB, WHO, UNICEF, WAHO and Save The Children, some trainings have been conducted in all 13 districts. However, huge gaps remain that should be addressed by this proposal. In the process of implementation of the RED and IMNCI strategies, we have learned that without a proper coordination mechanism in place, funding for a particular activity from multiple sources with multiple implementing partners will naturally lead to situations of inequity and inequality. This means that districts which attract better funding prospects will stand an advantage over the others with lower opportunities. Therefore, this proposal is designed to address such problems of inequity and inequality by ensuring an effective coordination mechanism.  *Objective 3*. An efficient PSM that is supported by LMIS is critical to quality health service delivery. This is reflected in the adage, which says no products no programme. A functional PSM that is operated by trained and qualified health staff will guarantee the availability of supplies to all levels at all times. Sierra Leone participated in the Universal Child Immunisation (UCI) in the 1990s. During that period, the ministry with support from UNICEF put together an effective and efficient vaccines management system including cold storage, which supported regular uninterrupted supply of vaccines and related commodities to all functioning health facilities in the country. With the said system, all facilities at any given point in time had adequate supply of vaccines and other supplies and this greatly contributed to the overall success of the immunisation campaign. We are convinced that having a functioning PSM that covers forecasting and quantification, procurement, storage, distribution and rational drug use will definitely improve on drugs availability at facilities at all times, and will undoubtedly positively impact on health service delivery. |
| * 1. Main Beneficiaries   *→ Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.* |
| The activities under objective one are geared towards improving the capacity of the facility and maintenance unit thereby facilitating the availability of functional health service equipment including vehicles and motor bikes, at all times. The beneficiaries of these activities are at several levels: health staff, general population and people in remote communities. The health workers will benefit by the use functional equipment which will enhance services delivery, improve moral, and increased productivity. The general population will have access to quality health services while those in remote communities can easily be accessed through the use of road worthy vehicles and motor-bikes. In the case of immunisation, the regular maintenance of cold chain by trained and qualified technical staff will facilitate more out-reach activities to remote and hard-to-reach settlements.  The activities under objectives two are to promote outreach service delivery. Outreach services take health care to people in remote and marginalised communities leaving far away from the health care services. This accounts for about 25% of the population who are un-reach and a further 15% who are constantly missed by static health services. The objectives therefore take health care services to deprived and isolated communities. Since most of the interventions in the out-reach service packages are maternal and child health, the ultimate beneficiaries of objective 2 are children under five years of age and women of child-bearing age.  Objective three is geared towards improving capacity of health workers in the periphery as well community health workers in the management of childhood illnesses. The primary beneficiaries are the PHU staff and the CHWs. However, the ultimate beneficiaries are children. The training of community health workers in IMNCI benefits the children in remote and marginalised communities.  The activities in this proposal are clearly linked with the general objective of the NHSSP, which is to strengthen the functions of the national health system of Sierra Leone so as to improve the following performance criteria:   1. Access to health services (availability, utilisation and timeliness) 2. Quality of health services (safety, efficacy and integration) 3. Equity in health services (disadvantaged groups) 4. Efficiency of service delivery (value for resources) 5. Inclusiveness (partnerships)   These activities are also contributing to the implementation of the Basic Package of Essential Services (BPEHS), which provides a comprehensive list of services to be offered at the five levels of the health system, namely: the community level, the maternal and child post (MCHP), the community health post (CHP), the community health centre (CHC) and the district hospital. The activities in both objectives 2 and 3 are contributing towards quality care at 4 levels of the health system.  The criteria for defining the Sierra Leonean BPEHS are:   1. services which will have the greatest impact on the major health problems 2. services that are cost-effective in addressing the problems faced by many people 3. services which can be delivered to give equal access to both rural and urban populations with a special emphasis on community based health interventions.   Perceivably well-trained health staff will deliver services according to established standards, aided by Community Health workers (CHWs) who will serve as a good link between the health facilities and the households in their respective communities. This will ensure active community participation in service delivery and utilization. It will also promote a feeling of ownership by the community and hence a strong foundation for sustainability will be concretized  Objective 4 is focused on providing drugs and vaccines to all population, but particularly to the people in hard to reach communities. People in hard-to-reach riverine areas will be provided constant supply of drugs and other items. |
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| **4. Performance Monitoring and Evaluation** |
| 4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework  *→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed template) as Attachment 4.* |
| 4.2 a) M&E arrangements  *→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.*  4.2 b) Strengthening M&E systems  *→ Please describe the M&E systems strengthening activities to be funded through this proposal.* |
| 4.2 a) M&E arrangements  Routine data are collected in the public sector through a network of some 1,200 Peripheral Health Units (PHUs), and 21 hospitals that are distributed throughout the country across 13 districts. The PHUs and hospitals gather data from client/patient registration forms, using tally sheets. These are collated onto a set of 8 paper based integrated reporting forms which are sent to the district office. Data submitted include that for adult and under five consultations, childhood preventive services, maternal health services, commodity availability, HIV and Tb services, availability of equipment, community services and mortality reporting forms. DHMT capture this data into an electronic District Health Information System (DHIS). The electronic data is forwarded to the Directorate of Planning and Information at the MOHS. The electronic DHIS database also allows integration of Open MRS software, which will permit development of a Hospital Information System. This electronic medical recording process has started with data for anti-retroviral patients recording at the nation’s teaching hospital and will be scaled up to all hospitals as a second step. The DHIS database will progressively be extended to capture data from other sources such as specific surveys, civil registration (births and deaths), research, supervision, private sector, civil society, resources and administrative records to give a broad picture of the country.  The final repository of health information is the Directorate of Planning and Information in the Ministry of Health and Sanitation.  The Ministry has an M&E Plan with a set of 22 core indicators with baselines and targets for tracking sector performance. There is also a longer list of programmes specific indicators for tracking performance of individual programmes. Data from the HIS are often provided to partners through:   * National Quarterly Bulletin * pivot tables * Quarterly Review Reports * Annual Review Reports * Evaluation Reports * Surveillance Reports * Briefs * Feedback meetings reports with stakeholders * Supervision reports   The M&E plan also has a schedule for surveys and assessments.  The indicators mentioned in this proposal are among the set of programme indicators in the National M&E plan. These indicators can be capture through the routine M&E systems and verified during national data quality assessments. |

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| The Health sector will also be conducting Annual Reviews, where partners will review sector Performance the previous year. The HSS indicators in this proposal as well as other HSS indicators will be among the set of indicators that will be assessed during the National review process to assess country progress.  **4.2 b) Strengthening M&E systems**  Even though much progress has been made in strengthening the M&E in the sector, certain specific areas still need to be strengthened. One of such areas is the use of data at health facility level. To facilitate this, trend charts will be printed for all health facilities and staff will be encouraged to use them.  Each Health facility will be provided with charts to help monitor progress in uptake of key child and maternal health services.  Secondly, a study looking at the existing barriers to accessing health care services will be undertaken. This is because, even though much effort are on-going in the country to address barriers to service uptake, other barriers come-up. It is critical that these new barriers be identified addressed.  M&E strengthening measures in this proposal would therefore be focused on improving the use of data at health facility level for decision-making and understanding the barriers to health services delivery. M&E will also be an integral aspect of the training of PHU staff in the RED approach. |

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| **5. Gap Analysis, Detailed Work Plan And Budget** |
| 5.1 Detailed work plan and budget  *→ Please present a detailed work plan and budget as Attachment 5.* |
| 5.2 Financial gap analysis  *→ Please present a financial gap analysis (and counterpart financing table for Global Fund applicants).* |
| 5.3 Supporting information to explain and justify the proposed budget  *→ Please include additional information on the following:*   * *Efforts to ensure Value For Money* * *Major expenditure items* * *Human Resources costs and other significant institutional costs* |
| * 1. Financial gap analysis   The Government and Development Partners have developed a 3-year Joint Programme of work and funding (JPWF) that guides the activities and investment decisions of Government, and the health sector development partners over the next three years. The JPWF is a prioritised subset of activities in the NHSSP, which outlines the priority interventions to be focused on and their resource and financing implications. The total cost of implementing the JPWF for the 3-years is US$ 473.6 million of which US$ 280 million has been committed by both government and partners. Government is contributing 27% of the committed funds and partners have committed the rest. There remains a gap of US$193.6 million equivalent to 41% of the total cost.  The support to the JPWF implementation is of two kinds, namely tied and untied. The tied support include support for specifics activities in the JPWF such as salaries payments and drug procurement and support to on-going projects, such the World Bank support Reproductive and child Health Project, the ADB support Strengthening District Health Services Project and Global Fund support. The untied support to implementation of the JPWF implementation in general.  From the JPWF, the cost of ensuring that health facilities are accessed within a 5km radius is US$ 11,641,980. in PHUs for 3 years is US$ 13,117,376. This however includes construction of health facilities and out-reaches services. The cost of providing out-reach services is about US$ 4million and the gap is about US$ 1.6million. GAVI HSS will contribute about US$ 1.5 million of the gap.  The cost of ensuring that there are drugs, functional bio-medical and medical equipment is about US$ 53 million. About 95% of this cost will go toward procurement of drugs and medical equipment. About US$ 2.5 will be used to procure bio-medical equipment and spare parts. This proposal is seeking about US$ 1 million from GAVI to support biomedical equipment maintenance. |
| * 1. In terms of value for money, the proposal will ensure that immunisation coverages are increased and the drop out are reduced by ensuring the vaccines prove immunisation are available and defaulter tracing is carried out and that cold-chain equipments are functional to ensure that vaccines are always potent. The proposal addresses key barriers to immunisation and will improve equity in immunisation between districts as well as better rich and poor. The proposal aims to improve immunisation as well as other reproductive and child health interventions in a very cost effective manner.   Major expenditure items were vehicles for distribution of drugs and other medical consumables, vehicles for supportive supervision, procurement of spare parts for cold chain and other medical equipments and the expansion of cooling facilities are district and national levels. The expansion of cooling facility stems from the need to expand the EPI programme to adolescence and the need for inclusion of new vaccines. As a result 45% of the total funds will be spent on infrastructure and equipment. |

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| **6. Implementation Arrangements, Capacities, and Programme Oversight** |
| **6.1 a) Lead Implementers (LI)**  *-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.*  *🡪 Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives*. |

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| **Lead Implementer:** |  |
| **Objective(s):** | 1) Facility Management unit  2) Child Health/EPI Programme  3) Directorate of Supports Services |
| *🡪Description of the Lead Implementer’s technical, managerial and financial capabilities.* | |
| The Facility Management Unit of the Ministry of Health and Sanitation is headed by Programme Manager, who has a degree in Medical Equipment engineering. The unit do not have a special administrative and financial sub-unit. However, they will not be handling large sums of monies as all funds for training will be paid directly to the institutions. This unit will handle only funds for supervision which will be provided on quarterly basis.  The Child health/EPI Programme is also headed by a Programme Manager, who is a medical doctor with vast experience in programme management. The Unit has a financial management unit, headed by a Finance Officer. The unit has successfully managed similar other projects in the past.  The Directorate of Supports Services (DSS) is headed by a Director. Within the Directorate is the stores manager and transport manager. The Directorate has managed previous projects for stores expansion and procurement of vehicles. | |

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| **6.1 b) Coordination between and among implementers** |
| *🡪Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.* |
| Each district or health programme receiving GAVI HSS funds will be required to submit a quarterly report on the activities conducted, constraints and recommendations to the Directorate of Planning and Information and send a copy to the Chairman of the Health Task Force.  These quarterly reports will be shared with all members of the health task and will be deliberated upon at the HTF meeting and feedback sent to the districts. The Directorate of Planning and Information send a quarterly report to GAVI Secretariat on the status of implementation of the planned activities.  Annual reports are also sent to GAVI Secretariat on progress in the impact, outcome and outputs indicators in the GAVI proposal. |

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| **6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*** | |
| 1. Will other departments, institutions or bodies be involved in implementation as Sub-Implementers? | *🡪 go to section 6.1 c) (iii) and 6.1 c) (iv)* |
| *🡪 go to section 6.1 c) (ii)* |
| (ii) If no, why not? | |
| ***HALF-PAGE MAXIMUM*** | |
| (iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe:   * The roles and responsibilities to be fulfilled; * Past implementation experience; * Geographic coverage and a summary of the technical scope; * Challenges that could affect performance and mitigation strategies to address these challenges. | |
| Objective 1 will have only one implementer (Facility Maintenance Unit) and 13 sub-implementers. The 13 sub-implementers will be the 13 DHMTs that will manage in the funds for fuel and repair of equipments within their respective districts. The DHMT have vast experience in managing programmes of that sort, and have implemented Global Fund and previous GAVI HSS support in the past. The DHMT has the relevant management capability as well as the financial management capability to manage such activities. No challenge is therefore envisaged in implementing this objective by the sub-implementers.  Objective 2 will have the Child Health EPI Programme as Main Implementer. There will be 13 sub-implementers, namely the 13 District Health Management Teams. Each DHMT will implement the RED training as well as the Micro-planning issues at the district level. The DHMTs have competent staff to manage these activities and train the PHUs staff. All the DHMTs have conducted similar trainings in the past. The challenge that is envisaged in implementing this training is that the RED training and the micro-planning exercises might take staff away from the health facilities for a prolong period of time. In facilities where there is only one health workers, this means that no health care will be provider for a prolong period of time, which may lead to reduced coverage. To mitigate this, DHMTs would be advised to send replacement health workers to temporarily provide services at such health facilities so that there is no break in service provision.  Objective 3 will have the directorate of Supports Services (DSS) as the main implementer and 13 sub-implementers, namely the DHMTs. The DSS will provide the specifications for the vehicles and trucks and the DHMTs will be responsible for managing the supplies trucks at district level and for ensuring that there are no stock-outs. The challenge will be they DHMTs may not have adequate funds to ensure that the trucks are properly maintained and serviced. To mitigate this, Local Councils will be asked to ring-fenced the amount of money that the DHMT will require for fuel and vehicle maintenance. | |

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| iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, explain why. |
| Civil Society Organisations are not involved as sub-implementers, the reason being that CSOs are already being supported to under-take monitoring of the Free Health Care Implementation, help in establishing Facility management communities and community sensitisation activities by both DFID and UNFPA.  Private Sector is also not involved as sub-implementers because we have not being able to get them to attend the meetings in the health sector. We intend to continue engaging them to be jointly implement with the public health system. |

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| **6.1 d)** **Strengthening implementation capacity**  (a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.  *🡪 Please refer to the* [*Strengthening Implementation Capacity information note for further background and detail*](http://www.theglobalfund.org/en/application/infonotes/). | | | | |
| Management and/or technical assistance **objective** | Management and/or technical assistance **activity** | **Intended beneficiary** of management and/or technical assistance | Estimated timeline | Estimated cost  *🡪 same as proposal currency* |
| *🡪 add extra rows as needed* | Technical assistance will be required to support the Ministry is undertaking an inventory of all equipment in the public health facilities and to capture this in a database. | Direct intended beneficiary is the facility management unit. However, the ultimate beneficiaries will be the general population. | 1 months | $ 10,000 |
|  | TA will also be required to provide on-the-job training for existing equipment maintenance staff and at the same timework with them to repair, service and install some of the equipments that are currently present in health facilities. | Direct intended beneficiary is the facility management unit. However, the ultimate beneficiaries will be the general population. | 6 months | $ 30,000 |
| (b) Describe the process used to identify the assistance needs listed in the above table. | | | | |
| A Terms of Reference will be developed for each TA and shared with WHO to get us 5 CVs of experts within the African region to provide the service. The CV will be revived by a technical evaluation team in the Ministry, against certain pre-determine criteria. The report of the evaluation committee will be sent to a Procurement committee for endorsement. Once endorsed, the recommended candidate will be informed in writing and a contract signed for the service. | | | | |
| (c) If no request for technical assistance is included in the proposal, provide a justification below. | | | | |
| ***HALF-PAGE MAXIMUM*** | | | | |

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| **6.2 Financial management arrangements**   * *Please describe:*  1. *The proposed financial management mechanism for this proposal;* 2. *The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.* 3. *Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.* |
| GAVI HSS funds will be sent to a Special Foreign currency account held in one of the commercial banks and the account will be that will be managed by the Director of Financial Resources in collaboration with the Top Management Team of the Ministry of Health and Sanitation. The account is an exiting account that has been opened for GAVI funds.  Request for funds by implementers (districts, technical programmes) will be made to the Director of Planning and Information. The Director of Planning and Information will receive requests for disbursement. He will check to ensure that the activity is one of the planned activities and the amount requested does not exceed what is in the plan. Once this is done he will endorse the request and forward to the Chief Medical Officer and the Permanent Secretary for approval.  Upon receipt of the approval the Director of Financial Resources will also ensure that the activity is in the plan and the amount requested does not exceed the amount for the activity. He will then make payment directly into the account of the implementing unit/agency.  Once the department has implemented the activity they will submit a report together with liquidation for the funds they have used. The returns from the district will be forwarded to the internal audit department to ensure that funds have been used for the intended purpose and is well accounted for.  The GAVI account will be audited after every 12 months and the audit report circulated to all key partners and HSSG members. |
| **6.3 Governance and oversight arrangements**   * *Please describe:*  1. *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);* 2. *The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;* 3. *Plans (where appropriate) to strengthen governance and oversight;* 4. *Technical Assistance (TA) requirements to enhance the above governance processes.* |
| The Health Sector Steering Group (HSSC) will be responsible for Governance of the HSS Grant. It is the second highest strategic decision making body in the sector. It is chaired by the Chief Medical Officer against the agreed TOR and in line with membership including Donors, NGOs, FBOs, CSOs and Directors and Managers in the Ministry of Health.  The HSSG has 7 technical Working Group (WG) to address health system issues. Whenever necessary, WGs may set up ad hoc joint sub-committees or task teams to address issues that cut across their respective mandates.  Activities under objective 2 and 3 will be managed Working Group on Integrated Service Delivery. This WG is responsible for the coordination of the integrated delivery of the Basic Package of Essential Health Services (BPEHS) including the referral chain and supportive supervision to ensure effective service delivery at all levels including community. It is also responsible for strategic guidance in the selection of the most appropriate and effective interventions in each of the technical programme areas.  The Working Group on Health Infrastructure Development and Maintenance will manage activities under objective 1. This WG will be responsible for civil works, utilities, transport, equipment, preventive maintenance of buildings and equipment, development of the medium and long term health infrastructure development and maintenance plan.  These working Group meet at least every fortnight to discuss issues under their TOR and report to the HSSG on a monthly basis. As and when necessary the HSSG may meet more regularly. |

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| **7. Risks and Unintended Consequences** | |
| **7.1 Major risks**   * *Please describe any major “internal” risks (within the control of those managing the implementation of the HSS support) and “external” risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.* | |
| **Risks** | **Mitigating strategies** |
| Government may not be able to recruit the additional staff required to strengthen the facility maintenance units at district level. | Other partners will also be approached for support to recruit staff with the relevant background for training as equipment maintenance staff. If this fails capable cold chain technicians will be trained to maintenance other health care equipment. |
| Poor management of medical wastes by health workers during out-reach | Health workers will be given adequate number of waste disposal boxes and will be told to dispose of all waste at the health facility and not within the communities in which the outreach are done. |
| Delays in release of funds by GAVI |  |
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| * 1. **Unintended consequences** * *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.* | |
| The cost of strengthening the supply chain management unit is very substantial and would require support from other partners. The current request to GAVI is just to start setting up the system. There is however the possibility the moment some partners learn that this aspect is receiving support from GAVI, they will direct their attention elsewhere and may not be inclined to provide the additional support required to establish an effective supply chain system. This will affect the attainment of targets and service delivery.  In order to mitigate this, partners will be informed of the total cost of establishing a supply chain system, and what will be achieved with GAVI support. The gap will be presented to the HSCC and HSSG. | |

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

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| **Optional Attachments**  *→ Please tick when the attachment is included* | | |
| *No.* | *Attachment* | ***✓*** |
| 6 | Joint Programme of Work and Funding | ***✓*** |
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