Application Form for:

GAVI Alliance Health System Strengthening (HSS) Applications

September 2008

Republic of Cuba

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

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

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

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

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Application for GAVI Alliance Health System Strengthening Applications

Annexes

Abbreviations and Acronyms

To the applicant

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

GAVI	Global Alliance for Vaccines and Immunization
HSS	Health System Strengthening
HSCC	Health Sector Coordination Committee
ICC	Interagency Coordination Committee
WHO	World Health Organization
PAHO	Pan American Health Organization
UNICEF	United Nations Children's Fund
WFP	World Food Program
MINSAP	Ministry of Public Health
MINVEC	Ministry for Foreign Investment and Cooperation
GDP	Gross Domestic Product
PHC	Primary Health Care
FMC	Cuban Women Federation
CDR	Committees for the Defence of the Revolution
ANAP	National Association of Minor Crop Producers
NIP	National Immunization Program
LBW	Low Birth Weight

Executive Summary

To the applicant

- *Please provide a summary of the proposal, including the goal and objectives of the GAVI HSS application, the main strategies/activities to be undertaken, the expected results, the duration of support and total amount of funds requested and the baseline figures and targets for the priority indicators selected.*
- *Please identify who took overall responsibility for preparing the GAVI HSS application, the role and nature of the HSCC (or equivalent), and the stakeholders participating in developing the application.*

The Cuban State, the Government, and particularly the Ministry of Public Health of the Republic of Cuba continuously implement programmes with a view to develop the National Health Care System, raise health standards and the quality of life of the population, improve the quality and efficiency of heath services and programs and address the demands and needs of the population, thus contributing to its satisfaction and well being.

To acheive this aim the Ministry drafts medium and short term plans that are implemented and assessed through a decentralized, participatory process together with the community, the civil society and other related sectors.

One of the main reference document is the "Projections of the Cuban Health System until 2015" aiming at defining a strategy to significantly improve the Cuban population health status. This strategy emphasizes on environment and behaviour related issues, establishing system organization strategies, management and evaluation. It also focuses on two major problems of the life cycle currently considered as top priorities: Mother and child health care and population's aging.

Even though **maternal mortality** has decreased considerably, it still does not reach desired levels and there are fluctuations at times that prevent achieving a sustained decreasing tendency. The reduction of **low birth weight** is substantial; though there are some identified cases mostly on the group less than 1500g which is considered as at very high risk even for immune-preventable diseases, as vaccination is not possible less than 2 500g weight.

The policlinic is the basic and pivotal institution of the National Health System. We are transforming the maternal homes into mother and child homes and strengthening doctors' consultation offices in the suburbs.

The first level medical network covers 99.8 per cent of the population, even in the most remote places in the country, areas which count on 187 consultation offices each with a physician, a nurse and resources to meet local needs and conditions. All Medical Consultation Offices implement comprehensive health care programs and among these, the Mother-Infant Health Care and the **National Immunization Programs** are top priority.

Consultation Offices get the support and guidance from the 498 general polyclinics. These polyclinics offer all the medical services, including promotion, prevention, recovery and rehabilitation, with high standards for the quality of services, and at the same time implement comprehensive medical care in areas with an average population of 25 000 and with the participation of the community and other concerned sectors.

Polyclinics assign priority to the programs and services in their respective areas, including training of personnel and research. They are the link for the integration with the hospitals and all the entities of the National Health System.

As part of the child and mother health program, there are 291 maternal homes located in municipalities and health areas. These homes work in close coordination with the basic health care community services and ensure an adequate evaluation of nutrition, weight gain, risks evaluation, health education and training and the preparation for a healthy pregnancy, labour, puerperium and care for the newborn by specialised staff with the adequate technologies.

The system is completed with 213 hospitals and 13 research institutes together with other institutions in charge of health care, training, services and production with well-defined responsibilities and required capabilities and thus meeting the highest standards of quality, efficiency and safety.

Medical care for low birth weight is granted in all the network of services: consultation offices, basic working groups, maternal homes and Polyclinics. In the second level of medical care there are 56 neonatology services in provincial and intermunicipal hospital, that ensure specialised care to all births. To provide care for very low birth weight (less than 1500g) there is a network of 19 regional specialised in selected provincial institutions.

Frailty and vulnerability of very low birth weight infants and their enormous demands for continuous, timely and comprehensive care requires the participation of several specialised services at the three levels of the system. Therefore, a close monitoring and assessment is indispensable.

Strengthening of health services, as an integrated program, includes also other services and actions:

- Strengthened consultation offices in the sub-urban areas for integrated comprehensive care in distant suburban areas in the municipalities that include rural and mountainous areas around the clock.
- Polyclinics with 24 medical specialties and state of the art technological resources for care, prevention, diagnose and treatment of acute or chronic diseases, elective or emergency diseases and rehabilitation.
- Mother-Infant homes in each Health Care area for care to pregnant women and newborns with geographic, social, nutritional or biological risks.
- Hospitals equipped with the required technological resources, including maternal-infant care, with highly specialized neonatology services to provide health care services to the very low birth weight and extreme low birth weight.
- Monitoring systems that are capable to identify timely, specifically, and reliably all the health risks and problems affecting very low birth weight infants.

The major obstacles identified to be dealt with HSS GAVI support are:

- Lack of resources in consultation offices in sub/urban areas that limit the capability for medical care, mostly in the maternal -infant program.
- The population from distant areas, especially mothers with infants, has to travel further distances from their respective consultation offices to receive the basic medical care they need.
- The number of maternal homes able to provide good health care services to mothers with a risk of having LBW infants is insufficient.
- Very low birth weight new born infants and infants with other medical care risks, do not count on adequate services for recovery and for a safe effective development.
- The functions of the Maternal-Infant Homes are not defined so far. The existing Manual for the Maternal homes has just been updated.

- The 291 existing maternal homes need to be converted according to the new health care model/profile. Some 207 new Homes need to be created to cover the needs of the 498 health areas.
- There isn't a computerized monitoring and evaluation system to allow an efficient communication and coordination for the continuity of medical care, in particular for infant under 1500 grams
- The visits and supervison to polyclinics, consultation offices and mother-infant homes are not as frequent and rigourous as they should be. This fact could compromise the efficient work of the local health system and especially the program of Mother-Infant care with all its components, including immunisation.

General expected results

Support from the Global Alliance for Vaccines and Immunisation for the Strengthening of the Health Systems will

- Better equipped and improved performance of municipal health systems,
- Enhanced access, efficiency and quality of the maternal homes and sub-urban polyclinics, mother-infant health and National Immunisation Program.
- Reduced mortality rate of newborns less than 1,500 grams

The main aims and objectives are the following

Aims:

1. Maintain national coverage by DTP3 above 98 %.
2. Reach DTP3 coverage above ≥ 80% in 95% of the municipalities.
3. Reduce the rate of Low Birth Weight to below 5%.
4. Reduce mortality rate in under five children to 6.0 deaths per thousand.
5. Reduce maternal mortality rate to 10.0 per 100 000 live births.
7. Increase to 85% exclusive maternal breastfeeding until 6 months.

Objectives:

1. Improve and extend mother-infant health services to 187 communities in remote areas and align them on the performance of sub-urban consultation offices by 2010.
2. Reduce low birth weight through care to mothers with LBW risk in maternal homes.
3. Speed up the nutritional recovery of LBW children through mother-child care in Mother-Infant Homes.
4. Implement the program of Mother-Infant Homes in 144 health areas and create 30 new Mother-Infant Homes by 2013
5. Contribute to the reduction of the mortality rate of newborns less than 1,500 grams by designing and implementing a monitoring system of the comprehensive care of very low birth weight from 2009.
6. Contribute to the adequate performance of the local health system by strengthening the monitoring and evaluation program for the municipal health systems from 2009.

Main strategies and activities:

- Continue to equip sub-urban consultation offices following the model established to fulfil the duties assigned and make space available for training and teaching personnel.

- Draft manuals on technologies and organization systems in Mother-Infant Homes, the program for medical care to low birth weight and mothers at risk, vigilance and information on very low weight and supervision and assessment of municipal health systems.

- Organize workshops and training programs for the personnel to implement these new technologies and programs.

- Purchase and distribute the basic complementary equipment for the sub-urban consultation offices and mother-infant homes, specialized neonatology services and supervision and assessment teams.

Funding

The requested finding is for seven years. To achieve the planned objectives, funding is amounting to 2 370 045 USD was requested for the period 2009-2015, calculated on the basis of births estimated for these seven years.

Support from the GAVI Alliance will further contribute to the nutritional recovery of expectant mothers and low birth weight infants. It will also expand coverage and access to immunisation services, particularly for low birth weight infants, improve access to specialized medical care with better opportunities and continuity, and improve preparedness and performance among health professionals and technicians.

The application process was coordinated by the Ministry of Public Health through its Divisions on Mother-Infant Health Care, Primary Health Care, and Epidemiology in charge of vigilance, prevention, diseases evaluation as well as the National Immunisation Program, the Division of International Relations and the Projects Unit. The Health Sector Coordinating Committee (HSCC) was constituted and involved with an expanded membership with the participation of other sectors and the civil society, to draft the proposal, discuss its content and prepare it for submission. The HSCC will be in charge of the follow-up and of the monitoring of the application implementation. Other United Nations specialized agencies (WHO/PAHO, UNICEF and WFP) and the Ministry in charge of foreign investment and economic cooperation are also participating in the process.

In Cuba, each sector has a plan to meet the population's needs. This process, in the case of health care, is prepared and evaluated by the Ministry of Public Health taking into account the decentralization at various echelons of the National Health System down to the Family Doctor Consultation Offices. This plan includes the objectives, human resources, supplies and financial resources for its implementation, operations, sustainability and development.

Support from the GAVI Alliance will contribute to strengthten this plan and to solving part of the faced problems. GAVI funding support will be integrated into the national health sector Plan.

Bearing in mind the limited resources available in hard currencies in Cuba to respond to the priority health needs and aspirations, efforts have been made to mobilize multiple funding sources to support to specific priority needs and activities within the national health planning and budgeting system.

Section 1: Application Development Process

To the applicant

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

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

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):
Health System Coordination Committee (expanded with several other health areas according to the needs submitted for this application).

HSCC operational since:
February 2008 based on the Interagency Committee and its work since 1993.
Organisational structure (e.g., sub-committee, stand-alone):

The HSCC, of the Ministry of Public Health, is composed of various national and external entities and member such as the Divisions of Mother-Infant Health Care, Primary Health Care, the Epidemiology Division, which is in charge of vigilance, diseases prevention and control and the National Immunisation Program, the area of Health Promotion and Education, the area of International Relations and the National Projects Unit. This last one was created to promote, guide, coordinate, control and assess projects and donations related to health programs and institutions, and belongs to the Division of International Relations.

The Cuban civil society, represented by organizations related with health, participates in the HSCC in designing health plans and policies, and in implementing, monitoring and assessment of such plans.

For this particular project, the HSCC organization was based on the previous experience of the Interagency Coordinating Committee (ICC) and the National Immunisation Program (NIP), new members were added to participate in the whole process for drafting and validating of the proposal. The Committee will also be responsible for the follow-up and monitoring of the implamantacion.

PAHO/WHO is also a member of the HSCC and at the same time the agency for technical cooperation and assistance and mobilisation of resources. Other United Nations specialized agencies (namely UNICEF and WFP) and the Ministry for Foreign Investment and Economic Cooperation are members of the Committee.

The HSCC, under the guidance of MINSAP, participates in planning, coordination and evaluation of all health initiatives supported by external funding resources within the framework of national plans.

Frequency of meetings:[1]
Six-monthly working frequency. However for the preparation of this particular application, the working plan scheduled includes meetings every two weeks.

Overall role and function:
The Health Sector Coordinating Committee analyses the current health situation and evaluates services, programs and plans, particularly those related to primary health care, mother and child health, immunisations, promotion and education. The HSCC contributes to the designing of health care policies and plans and identify the needs in terms of domestic and external sources and their integration into the Health Sector National Plan.
The Committee also review the Annual Plans and reports and identify limitations and possible solutions and new cooperation activities.

[1] Minutes from HSCC meetings related to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting when the application was endorsed. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.
Minutes from HSCC meetings related to HSS are attached, please refer to ANNEX 8.

To the applicant

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

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The Ministry of Public Health, through its Vice ministries for General Medical Care and Epidemiology, the Division of International relations and its Unit of Projects. Other areas of medical services also actively participated, namely the Division of Mother-Infant Health Care, Primary Health Care and Epidemiology. PAHO/WHO encouraged and supported the process.

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

The Technical Sub-committee, created Ad hoc, and coordinated by the Vice-minister in charge of Medical Care at MINSAP. The national Divisions in charge of Primary Health Care, Mother Infant Health care, Epidemiology, Extended Immunisations Program and the members of the Interagency Coordinating Committee participated.

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

- In November 2006 an application was submitted to the Global Alliance for the strengthening of the National Health System. This application was revised and a number of comments and recommendations were to be included for the follow-up and final submission.
- Based on the systematic analysis carried out at the Ministry of Public Health together with Government officials, and taking into account the need to strengthen the health system, particularly the areas of primary Health Care and the Mother-Infant Health Care Program, a Workshop was carried out to determine the major barriers existing in the Health Care System at the national level which limit sustainability or improvements in vaccination coverage. Representatives from the Divisions involved participated in the workshop held in October 2007.
- In February 2008, the Health Sector Coordinating Committee was created. In its first meeting, its members discussed the objectives for the preservation and improvement of the achievements obtained in Mother-Infant Health Care. The Committee reached consensus regarding the actions to be adopted for the preservation and improvement of the achievements obtained in Mother-Infant Health Care taking a social, community approach in a health care system in which vaccination is a priority. The Committee also defined the scope of the application for HSS-GAVI to direct the efforts to the needs that have not been previously met by other cooperation projects.
- A technical team was created to draft the application. All related areas of MINSAP participated in drawing up the proposal with support from PAHO/WHO
- The team prepared a first draft of the proposal during March and April 2008. This first draft was revised with the HSS-GAVI and PAHO/WHO regional focal point.
- The second draft of the proposal was validated by directors and specialists of the Ministry of Public Health, provincial health departments and consultants from UNICEF and PAHO.
- This second draft was also analysed and discussed with the health sector committee for its approval.
- A second revision was made on 19 and 20 May together with specialists from WHO, PAHO, national and foreign experts. Recommendations were discussed in the workshop, and several were included in the proposal to be submitted.
- Suggestions from other experts who are not part of the Committee were taken into account. The final draft was submitted to the Ministry of Public Health for approval.

- The Ministry for Foreign Investment and Economic Cooperation and the Ministry of Finances and Prices finally approve the proposal.

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

This proposal was revised by the technical teams of the Ministry of Public Health and Vice ministers in charge of Medical Care, and Hygiene and Epidemiology, the Ministry of Finances and Prices, the Ministry for Foreign Investment and Economic Cooperation (MINVEC), the PAHO/WHO Representation in Cuba and UNICEF.
Discussions were critical and thorough, with wide and analytical remarks from all participants, which in turn generated significant suggestions and recommendations now container in the proposal.

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

The Minister of Public Health and the Minister of Finances and Prices

To the applicant

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

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

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

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Vice ministry of Medical Care Dr. Joaquín García Salabarría	Ministry of Public Health	Yes	Preside over the CCSS on behalf of the Ministry of Public Health.
Vice ministry of Epidemiology Dr. Luis Estruch Rancaño	Ministry of Public Health	Yes	Coordinate the contribution of technical areas under their responsibility for the implementation of the proposal.
Division of International Relations Dr. Néstor Marimón Torres	Ministry of Public Health	Yes	Call for meetings of the CCSS. Draft minutes and memories and follows-up agreements. Provide information on cooperation projects. Provides technical assistance and assessment. Coordinate and evaluate interagency actions including fund allocation and flow.
Director of the National Division in Charge of Mother-Chid Care Dr. Longina Ibargollen Negrin	Ministry of Public Health	Yes	Coordinate technical contributions for drafting proposals.

Responsible of the national Unit of Projects and Donations Dr. Alicia Izquierdo	Ministry of Public Health	Yes	Establish coordination with areas involved in the project and ensures the design is oriented to the Health care Projections for 2015.
Director of the National Division in Charge of primary Health Care Dr. Cristina Luna	Ministry of Public Health	Yes	Participate in submission of project. Define concepts and actions. Provide information.
Director of the National Division of Epidemiology Dr. Manuel Santín Peña			
Head of the National Immunisation Program Dr. Marlen Valcarcel			
Lic. Dagmar González Grau Director of International Economic Organizations	Ministry for Foreign Investment and Economic Cooperation	Yes	Evaluate and approve the project.
Representative of PAHO/WHO Dr. Lea Guido López.	PAHO/WHO	Yes	Revise consistency of the project. Ensure interagency coordination. Monitor and evaluate the process.
Representative of UNICEF Mr. José Juan Ortíz Bru	United Nations Children's Fund. (UNICEF)	Yes	Revise consistency of the project. Ensure interagency coordination. Monitor and evaluate the process.
Representative of WFP Mrs. Myrta Kaulard	World Food Program		Revise consistency of the project. Ensure interagency coordination. Monitor and evaluate the process.
Lic. Yolanda Ferrer	Cuban Women Federation	Yes	Make suggestions according to needs. Evaluate relevance of the project and define participation of the organization in the implementation of the proposal.
Lic. Orlando Lugo Fontes	National Association of Minor Crops Producers	Yes	Make suggestions according to needs. Evaluate relevance of the project and define participation of the organization in the implementation of the proposal.

To the applicant

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

1.4: Additional comments on the GAVI HSS application development process

In the strategy for the strengthening of the National Health System, particularly Primary Health Care, the Mother-Infant Health Care Program and the National Immunisations Program, the civil society, government agencies and other sectors related define priorities, take surveys, channel and process the demands and needs of the population, and participate in the evaluation and assessment.

This proposal, in considering sub-urban and community services, highly related with mother and child health care, primary health care and immunisations, has been discussed mainly with local authorities and with government and non-governmental organizations also related with the issue, namely the Cuban Women Federation, the Committees for the Defence of the Revolution and the Association of Producers of Minor Crop.

The Cuban civil society is composed by many diverse mass organizations and non-governmental associations. These participate, depending on their respective interests, in the management of society in the corresponding space and time. In the case of health care, participation includes designing policies and drawing up, implementing and evaluating health plans and strategies, mostly through the Health Councils in the various levels of the government.

The government (People's Power), at the national, provincial, and municipal levels, the people's councils and constituencies subordinate to the health sector. They are responsible for guiding, facilitate work and evaluate all plans and programs aimed at meeting the needs and demands of the population within the framework of the State's policies, regulations and budget and at the same time encourage, guide and evaluate the participation of other sectors, the civil society and the community in the health programs and actions that require their participation.

Private practice in the health sector, carried out by a few dozens of individual physicians and found mostly in the capital of the country and in some provincial capitals, can provide only limited outpatient consultation to a reduced number of people. These individuals get full support from the National Health System but they don't participate in management of the system. The State-funded, unique, universal National Health System is accessible for all and provides full coverage to the population in terms of promotion, prevention, treatment, control and rehabilitation.

Section 2: Country Background Information

To the applicant

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

2.1: Current socio-demographic and economic country information[2]

Information	Value	Information	Value
Population*	11.277.705	GNI per capita**	1170 $US
Annual Birth Cohort*	112,472	Under five mortality rate*	6.7 / 1000 nv
Surviving Infants***	111,876	Infant mortality rate*	5.3/ 1000 nv
Low Birth Weight Ratio*	5.2%	Percentage of Government expenditure on Health as proportional of National Budget**	14.7%
Percentage of GNI allocated to Health**	10.6%		

**Statistical Yearbook*. 2007 MINSAP
** Ministry of Finances and Prices, (2007): State Budget, Liquidation report, 2006, La Havana.
*** Surviving infants = Infants surviving the first 12 months of life

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

To the applicant

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

2.2: Overview of the National Health Sector Strategic Plan

According to **Cuba's social policy** the State as responsible for health care and the citizen is the beneficiary. This policy is oriented towards the sustainable human development with extremely high standards in terms of wellbeing and quality of life, mostly in the sectors of health care, education, culture, employment, social security and social welfare.

The socio-economic model implemented since 1959, has brought about significant changes in the health status of the population, an expression of the priority given to this sector and of the efforts made in the socio-economic area, as well as in the qualitative changes attained in the life standards of the citizens as a result of the policies for full employment, social protection, equitable distribution of productions, basic needs coverage through a wide network of social services and community participation.

After the collapse of the socialist block in 1989 Cuba had to FACE a sudden and at the same time dramatic reduction of imports, which caused a significant reduction of the GDP, worsened by the blockade imposed by the United States and the Helms-Burton and Torriceli Acts. All this intensified **the crisis and made more difficult the economic recovery of the country.**

Urgent and dramatic measures had to be adopted to prevent collapse of the basis established in all previous years and to maintain the achievements. However, there were severe problems to the infrastructure and to the resources available for the various sectors, particularly to the National Health System, which faced a 70% reduction of the Freely Convertible Currency fund. Nevertheless, as an expression of the high priority granted to the health sector, the budget in National Currency was increased steadily.

The State budget ensures distribution of funds among the various sectors of the economy. The health sector is a particularly high priority for the government, as it is an essential component for the citizen's quality of life. In 2007, 3.193,3 million Cuban pesos were earmarked for investments in the health sector, for a 23.0% increase as compared with 2006. Over 60% of the budget expenditures were allocated to health care, education, social security and welfare.

Health expenditures amounted to 14.7% of the State budget and 10.6% of the Gross Domestic Product. About 77.6% is earmarked to the local budget of the 14 provinces and their 169 municipalities and 22.4% to MINSAP and its national programs. Polyclinics receive 31.6% of the national budget and maternity hospitals get 1.5%.

The state budget is practically the only source of funding for the health sector, a significant difference compared with other countries. Another significant feature of the Cuban budget is that it is divided into two types of currencies: the Cuban peso, or national currency for salaries obligations and purchase of some products and services and the Cuban Convertible Peso (CUC) hard currency used internally in the country for acquisition of products and services commercialized in the country.

The State budget in Cuba is **the financial plan** that centralizes, distributes and redistributes most of the national revenues aimed at boosting the economy and at raising the population's wellbeing. The state budget is funded from the contributions of state enterprises, taxes and other contributions from

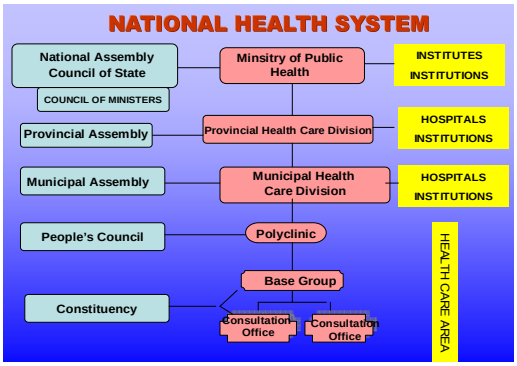
the other non-governmental sources and private citizens. Funding, which is panned based on this budget, ensures a better concentration and use of resources in sectors that are a priority.

The budget allocated for the health care sector, in national currency, **is structured in a decentralized manner** based on the overall, comprehensive and integrated balance between the national plan for the sector and the territorial plan. The hard currency component of the budget is managed in a centralized manner taking into account its limited availability. Funds for investment and modernization of infrastructure are drawn from the State Budget, though some of the contributions from external donations are included in the national budget. When donations are made at a specific local level, they are included into the plan for resources allocation to the given territory or unit.

The Health Care Plan is based on the analysis of the specific health situation, from the consultation offices up, that is, to the polyclinic, the municipality and the province to the national level. The plan describes the objectives and goals to be achieved, the actions to be implemented, the services to be provided and the resources needed. At the municipal and provincial levels these plans are implemented in each of the institutions existing in the territory (maternal homes, hospitals, dental clinics, elders' homes and others). Plans are subject to the approval of the highest level, and therefore the Health Care Plan is drafted with a centralized budget and centralized resources allocated for it.

The social and state managed nature of medical care, universal accessibility to resources provided for free, its prophylactic orientation, the implementation of scientific and technical developments, as well as the participation of the community and international solidarity are the **principles that support the policies** and determine priorities, structures, organization and performance in the National Health System. Citizens do not have to pay anything to receive any of the health services, which they are provided to meet needs and regardless of their income, place of residence, gender, race or any other condition. None of these mark differences in the access or use of health care services.

From the geographic point of view, **the country is divided** into 14 provinces and 169 municipalities. The government, called People's Power, is organized from the national level to the lowest unit, the constituency, core of governmental management, formed by a population of approximately 2000 inhabitants. Local governments guide, among other sectors, the sector of health care, and are responsible for guiding, managing and evaluating plans and programs so as to face the problems and meet the needs of the population within the framework of the policies and regulations and abiding by the State budget allocated. Local governments also encourage, guide and evaluate the participation of other sectors, such as the civil society and the community, in the programs and the actions that would require their participation and assistance. Territorial Divisions of Health Care, a vice-presidency within the local government counts on specialized resources for this.



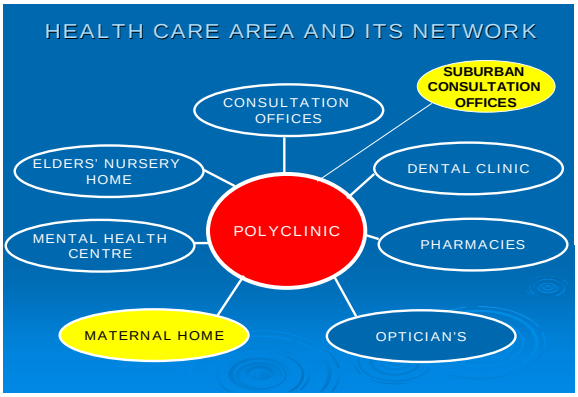
The System, is organized in levels based on the harmonic fusion of the Public Health Sector with sciences and medical practice in an advanced model of Primary Health Care The Ministry of Public Health centralizes the normative, methodological and evaluation capabilities and at the same time the largest investments and distribution and allocation of medical and non-medical technologies, though sometimes, significant resources are locally mobilised.

The network of services, harmonic and comprehensive, is structured based on the first level of health care.

As the **gate to the system** there are over 14 000 consultation offices in the communities, each with at least one doctor and one nurse providing primary health care to 99.8% of the population even in the most remote areas. Some 187 consultation offices are located in sub urban areas, covered by a family doctor, nurse and special resources to meet the particular conditions of the place. The policy of the system aims at providing more and more specialized high quality services to the population, especially the population living in areas of difficult access.

All **Medical Consultation Offices** implement the Family Medicine Program, which includes, among other services and features, special subprograms such as Mother-Infant Health Care and the Extended Immunisations Program. These constitute a high priority within the health policy of the country and are allocated resources directly by the polyclinic of the health area to which they belong. See Annexes 4 and 9.

Consultation offices are divided into categories. In the fulfilment of their functions, consultation offices receive support from **498 polyclinics,** considered the "basic institution" of the system, as they are responsible for comprehensive primary health care of the individuals, the families, and the community and for the preservation of the environment, in a socio-geo-demographic space called **Health Care Area.** The Area includes a group of institutions associated to the polyclinic that provides medical and health services to approximately 30 000 inhabitants.



The Polyclinic provide 25 health services, namely promotion, prevention, recuperation and rehabilitation with modern technologies and with a high level of resolution of problems and diseases through complex actions, both at the individual level and at the population level with the collaboration of other sectors and the community. Polyclinics also perform other managerial actions, especially vigilance, monitoring and assessment, training and education of human resources, post graduate courses, research projects, etc. They are the link between hospitals and the rest of the units in the Health System.

Integrating the Health Area are **Maternal homes**, institutions specialized in mother-infant health care that ensure nutrition, weight gain, risk control, education for a better health and preparation for the follow-up of pregnancy, labour, birth, puerperium and further care for the newborn by specialized personnel and with the use of adequate technologies.

However, not all health areas have maternal homes. In such cases, expectant mothers are cared for in the municipal capitals. The 291 existing maternal homes count on their own independent budget allocated from the municipal budget, internal complementary services of the polyclinic and of specialized hospitals and at the same time receive the support of the community and other sectors.

The current strategy will expand the concept of the Maternal Home to **Mother-Infant Home for Nutritional Recovery**, which means the mother with her low birth weight infant will return to the home, to the place where they both can be provided with the best health in an out-of-the-hospital environment and at the same time with an adequate specialized follow-up focused on the comprehensive aspects of growth, development and nutrition. The patients will be able to stay, depending on their needs up to one year (the infant will be one year old by then) and will receive all the necessary health care services including the vaccination scheme.

Each Health Area will have one institution of this type to increase coverage and accessibility and thus make a stronger bond with the area of residence in the community and to facilitate provision of services by the polyclinic at the same time increasing quality and evaluation. Annexes 5, 6 and 7.

The second health care level counts on 213 hospitals integrated with other medical teaching institutions that provide medical attention as well as services and at the same time teach and train personnel. The responsibilities of these hospitals are well defined and are subject to a program of strengthening, expansion and modernization that will enable these institutions to increase their diagnosis, treatment and therapeutic possibilities capabilities with state of the art technologies and high standards of quality, efficiency and safety for the patient. The program includes the use of information and computer Technologies in all the processes for more efficiency and better control.

The third health care level is represented by 14 institutes and 3 national reference hospitals that provide medical attention and at the same time, teach and train personnel and carry out research projects of a very high technological level. These hospitals are contacted for reference and counter reference by the subregional network of specialized services.

The Cuban population, 11.277.705 inhabitants, 75.8 % living in urban areas, has had a very low growth rate in the last years. Its structure, characteristics, and health status correspond to a high level of aging in which chronic, degenerative diseases are the foremost causes of mortality, morbidity and risk.

Children have been the most benefited in terms of mortality rates in Cuba. Mortality rates in children less than five year live births represents 1.1% of children's death for all ages. The structure of mortality by components and causes corresponds to the level of the indicator. Mortality rate, its major component, shows a rate of 5.3 per 1,000 thousand live births.

The reduction of **maternal mortality rate** to 21.3 per 100 000 live births does not reach levels according to the rest of the program's indicators and there are fluctuations in time that do not manage to stabilize a sustained decreasing trend.

The reduction of **low birth weight**, the control of social and environmental risks, the prevention or elimination of congenital malformations and the control and comprehensive care to mother and child are essential factors in the achievement of these goals. In spite of the 5.2% rate achieved, there are certain reservations identified, mostly in the 1500 g. and 1000 g range, considered very high risk infants, highly vulnerable even to immune preventable diseases, for they can be vaccinated while they are under 2 500 g.

Care to low birth weight infants is provided in the whole network of services: consultation offices, basic working group, Maternal home and Polyclinic. There are 56 neonatology services in the second level of health care in provincial hospitals and inter-municipal institutions, thus ensuring specialized health care for all newborns. For health care to very low birth weight infants (less than 1500g) there is a network of 19 specialized services in appointed regional and provincial institutions.

The vulnerability and frailty of very low birth weight infants and their many needs and demands for comprehensive, continuous and timely health care requires the participation of several specialized services found in the three levels of the system and at the same time a thorough follow-up in their medical care including reference and counter reference procedures in which a rigorous monitoring and assessment of the processes are indispensable.

From the very moment in which the risk of low birth weight is identified in an expectant mother, a special follow-up process is implemented during the whole pregnancy and until delivery. This process

involves the family doctor, the polyclinic and its basic specialized work teams, the maternal home and the corresponding maternity hospital of the region.

When the infant is born, always in a hospital with neonatology service, the municipal health division and the health area are notified and are responsible for the follow-up, until infant and mother are discharged having received the required health and medical care they need, including vaccination.

The protection against 13 **immune-preventable diseases** has made possible eradication of six diseases and two possible severe complications. Morbidity and mortality caused by the rest of such diseases have been dramatically reduced. See Annexes 13, 14

In 1962, infectious diseases amounted to 13.3% of total deaths. These diseases currently amount to barely 1.1%. In the past four decades, there has been a progressive and steady substitution of these diseases as major causes of death by chronic, non communicable diseases which currently cause more than 90% of deaths in the country.

Cuban **civil society** participates actively in the management and implementation of health programs and services and integrates Health Councils in all the levels of the system represented by the organizations that work more closely with the health sector, the Committees for the Defence of the Revolution, the Cuban Women Federation and the National Association of Minor Crop Producers.

The programs for Mother-Infant Health Care, Extended Vaccination, Elders' Care and Education for Health are the one with the most active participation, and in the case of services, family doctor consultation offices, particularly suburban consultation offices maternal homes and elders' nurseries.

These mass organizations participate in the decision making of the sector's policies at the corresponding level, from the drafting of the plan, analysis of the health conditions in the areas to monitoring and assessment. Working with their own resources, these organizations mobilize and involve the community providing educational information and supporting management even with supplies to local services and institutions such as Family Doctor Consultation Offices and Maternal homes specifically with the preparation of food, cleaning and sanitation of premises, washing, transportation, maintenance and repairs.

The National Health Care Plan[3]

In the 1980s, the country and consequently the health sector drafted five-year period plans that were left aside as a result of the deep economic crisis of the 1990s and the survival economic organization adopted. In 1992, however, and in spite of the many budgetary and financial difficulties and uncertainties, a health care program until 2000 was elaborated to face not only the existing health problems, but also those health problems that could be expected, adapting all services and programs to the economic and social situation of the moment. The program launched training and education of a large number of human resources in the use of technologies for primary health care and the promotion and information about health problems and their prevention, alternative medicine and participation of the community and other sectors of the population.

The results obtained in the general health conditions of the population, the efficiency in the services and programs, teaching of human resources and general strengthening of the health system within the context of the new political, economic, social, demographic and epidemiological scenarios enabled the sector and at the same time forced the sector to work in the design in the design of a long-term

[3] The National Health Care Plan is called officially "Projections for the Cuban Public Health until 2015". Ministry of Public Health of the Republic of Cuba. January 2006. ANNEX 3 presents a summary of this Plan.

Program 2006-2015, aimed at improving the general health status of the population taking into account all significant components and factors focusing on a risk and protection approach for specific population groups.

Drawing-up of the Plan and implementation of decisions was approved and supported by the governmental authorities and the leadership of the Party, involved the civil society and the health related sectors as well as organizations and scientific, assistance, teaching institutions and services and production institutions in the system. It followed a strict methodology for the analysis of the problems and for the identification of the basic issues, and established the goals based on the capabilities and the possibilities of the sector to meet and implement specific strategies with well-known impact.

The Plan stressed on the factors related with environment and behaviour and involved for its implementation the inter sector movement and the Cuban civil society. It also takes into account the major health problems affecting and threatening the population including risks of introduction of diseases from abroad paying special attention to the problems of the life cycle that are considered a high priority: health care of mother and child an population aging.

From the point of view of the health system, the Plan prioritizes service strengthening at the local level, or Primary Health Care. To this aim, it transfers state of the art technologies of health care to the basic health care unit thus consolidating the polyclinic as primary health care institution but at the same time closely integrated in a system with the hospital and other institutions, reinforcing and expanding the role of maternal homes as the institution responsible for the control of mother and child risks before and after birth.

Teaching and training of human resources is carried out through novel concepts and technologies in which the teaching scenario is moved to the polyclinics and consultation offices in the communities thus expanding and universalizing teaching.

Hospitals were also subject to a process of strengthening, expanding and modernisation that enhanced and improved their capacities for diagnosis and treatment with state of the art technologies thus providing higher quality standards, efficiency and safety for the patient. Information and computer technology is introduced as part of this process providing more efficiency in professionals' performance as well as in the services and the system in general.

The Public Health Projections for 2015 are the programmatic instruments that outline the health care purposes, objectives and goals as well as the way the system must be organized and how it should work for their achievement. Though Annex 3 describes them, taking into account their close relation with the proposal, bellow are some of the elements in two key areas: **Mother-Infant Health Care and Primary Level of Health Care.**

Consolidate and improve the levels already achieved in mother and child health care.

The following goals are designed:

1. Reduce infant mortality rate to 4 per thousand live births.
2. Reduce mortality rate in infants less than five years to 6 per thousand live births.
3. Reduce maternal mortality rate to 10 per thousand live births.

Some of the guidelines designed to achieve these goals are:

- Consolidate the program to prevent low birth weight.
- Encourage breastfeeding ensuring exclusive breastfeeding until 6 months.
- Manage an efficient protection to very low birth weight newborns and malnourished infants by the health care system and the community.
- Increase birth rate with special emphasis in couples with infertility problems
- Improve and perfect baby care and infant care and control of child growth and development.
- Promote educational campaigns aimed at reducing unwanted pregnancy and abortion practices.
- Identify and monitor female population at risk of preconception and raise the quality of prenatal and perinatal medical care improving the conditions in maternal homes, improving perinatal, delivery, birth puerperium and neonatology emergency services.
- Raise the quality of woman and child medical care perfecting the technological, organisational and clinical management models in existence.

Raise the quality and efficiency of the comprehensive health care, emphasizing in the First Level of Health Care.

To this aim, an integrated health care strengthening program is implemented, which emphasizes, among other actions, in:

- Strengthen consultation offices in sub urban areas for around the clock health care to the population in rural and mountainous areas and distant communities and small towns.
- Polyclinics with 25 medical specialties and state of the art technologies for prevention diagnose and treatment of both acute and chronic processes, elective or emergency and rehabilitation.
- Mother infant homes in each Health Care Area for medical attention to pregnant women and infants less than one year with geographical, social, nutritional or biological risks.
- Hospitals equipped with state of the art technologies for mother-infant health care including specialized neonatology services for medical attention to very low birth weight and extremely low birth weight infants.
- Systems of health vigilance capable of timely, specifically and reliability identifying health risks and problems, such as those affecting very low birth weight infants.
- Systems for monitoring health programs and services to ensure comprehensive, periodic and thorough evaluation of the performance of all the health services provided, particularly family doctor consultation offices, polyclinics and mother-infant homes.

Monitoring and assessment of services and programs is an essential and inseparable part of the Health System. It is ruled according to methodologies established art the national level with the participation of all levels in the health care system even those in the periphery, with the participation of the local community, aimed at expanding its scope in time and in space.

The system for monitoring and assessment is unique and it includes the specific and specialized actions of the programs and projects implemented at the territorial level.

Section 3: Situation Analysis / Needs Assessment

To the applicant

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

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

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

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

3.1: Recent health system assessments [4]

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Analysis of Health Sector	MINSAP	Assessment of status of health, programs and services	2007
Projections for the Primary Health Care	MINSAP	Primary Health Care Program of Family Medical Care System	2007
Projections for the program of Mother-Infant Medical Care	MINSAP	Mother Infant Health Sub Program of Low Birth Weight Assessment of maternal homes	2007
Assessment and projections of the National Immunisation Program	MINSAP	Immune-Preventable Diseases and Watch	2007

[4] Within the last 3 years.

To the applicant

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

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

- Difficult access of mothers and infants to resolvent health care services in distant populations.
- LBW incidence delays protection against some immune preventable diseases.
- Nutritional recovery of LBW children in exclusively hospital environment limits the efficiency and quality of medical and health care and increases risks.
- Vigilance and monitoring system for very low birth weight infants exists only in the 19 neonatology reference centres.
- Limited capacity of the municipalities for monitoring and assessing health care programs and services, especially in the periphery.

3.3: Barriers that are being adequately addressed with existing resources

- Suburban consultation offices with reinforced health care team in 187 distant areas.
- Creation of a model for equipping institutions in the First Health Care Level, including sub-urban consultation offices.
- Creation of a Government program for assigning basic equipment to Primary Health Care establishments, including sub-urban consultation offices.
- Strengthen maternal homes to turn them into Mother-Infant homes. The goal will be to create on such institution in each of the 498 health areas.
- With the support from UNICEF and of the Asociación Navarra Nuevo Futuro, the program was implemented in the five eastern provinces and in the City of Havana. The plan establishes coverage in all the health areas in the eastern provinces with the support from UNICEF.
- There are currently 291 maternal homes.
- A specialized health care program is being implemented for newborns less than 1500 grams to prevent and control risks. As part of this program MINSAP is extended and strengthening the network of neonatology services in 19 hospitals. These neonatology services are being implemented at the regional level with a greater integration to the local health care system, especially the first level of health care.
- A comprehensive monitoring, supervision and assessment system is implemented in the municipal and provincial health care systems. These include the processes and results of all the functions and components in the health care with a methodology especially designed for this objective.

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

- Lack of resources in suburban consultation offices that limit the quality of the health care provided, mostly in the mother and infant health care program.
- Population in distant areas, especially, mothers and infants have to travel beyond suburban consultation offices for basic health care services.
- The number of maternal homes and their capacity for health and medical care to mothers with risk of LBW are insufficient.
- Very low birth weight infants and other risk newborns do not receive adequate health services for their proper recovery and for an effective and safe development.
- The functions of the Mother and Infant Home are not well defined yet as the manual for health care in maternal homes was updated.
- Need to turn the 291 Maternal homes to the new concept and create 207 new Mother-Infant Homes to cover services in the program for the comprehensive medical care to infants of less than 1500 grams is inefficient and lacks the necessary control mechanisms for the timely and effective participation of the corresponding services, including immunisation services given the lack of an automated monitoring and evaluation system that would facilitate communication and coordination in the community.
- Visits to polyclinics, consultation offices and mother-infant homes, are not carried out with the frequency and the thoroughness established by the System. This fact could compromise the efficient performance of the local health care system and especially the mother-infant health care system with all its components, including immunisation.

Section 4: Goals and Objectives of GAVI HSS Support

To the applicant

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

4.1: Goals of GAVI HSS support

1. Maintain national DTP3 coverage above 98 %.
2. Obtain a national DTP3 coverage above ≥ 80% in 95% of the municipalities.
3. Reduce Low Birth Weight Rate to less than 5% at the national level and less than 5.5% in the five eastern provinces.
4. Reduce mortality caused by low birth weight and particularly in infants under 1500g in 50%.
5. Reduce mortality of children under five to a rate of 6.0 deaths per thousand.
6. Reduce mother mortality to a rate of 10.0 per 100 000 live births.
7. Increase exclusive mother breast feeding until 6 months to 85%.

4.2: Objectives of GAVI HSS Support

GAVI HSS funding will contribute to eliminate barriers that prevent the best performance of municipal health systems, especially mother-infant homes and suburban consultation offices, mother-infant health care, the Extended Immunisations Program and monitoring, vigilance and assessment systems, that will make possible:

1. Improve provision of mother-infant health care services in 180 communities in places of difficult access and in the same number of suburban consultation offices that need to be equipped to increase their resolvent capacity by 2010.

2. Reduce incidence of low birth weight through health care to mothers with LBW risk in maternal homes.

3. Speed up nutritional recovery of LBW infants through mother-infant health care in Mother-Infant Homes.

4. Implement the Program of Mother-Infant Homes to contribute to the expansion of services and functions in 170 health care areas, turning 140 maternal homes into Mother-Infant Homes and creating 30 new Mother-Infant Homes until 2015.

5. Contribute to the reduction of mortality of newborns less than 1,500 grams through the design and implementation of a monitoring and evaluation system for the comprehensive health care to very low birth weight newborns from 2009.

6. Contribute to the adequate performance of the local health care system by strengthening the monitoring and assessment program established for municipal health care systems from 2009.

Section 5: GAVI HSS Activities and Implementation Schedule

To the applicant

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

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

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

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

To the applicant

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

5.1: Sustainability of GAVI HSS support

The Cuban State, the Government and Cuban Society in general consider the Health Care Sector as one of the highest priorities. The recovery process occurring in the country herald new growth and development perspectives.

The sustained increase of the GDP, the Percentage of Public Expenditures in the Public Health sector and of the Budget assigned to the sector will facilitate the continuity of the activities undertaken with GAVI support and their development.

The high priority granted, within the national health care plan, to primary health care, to the mother-infant health care program, to low birth weight infants, to maternal homes and to health vigilance is clearly expressed in the achievements obtained and in the resources allocated to these priorities.

We count on our highly qualified technicians and motivated personel for the preventive maintenance and best use of the equipment and means obtained through GAVI HSS Support.

The GAVI HSS support will be fully integrated into the national health planning and budgeting system and therefore benefiting from the attention of the whole national and peripherical actors and authorities.

5.2: Major Activities and Implementation Schedule

Major Activities	Year 1 (2009)				Year 2 (2010)				Year 3 (2011)				Year 4 (2012)				Year 5 (2013)				Year 6 (2014)				Year 7 (2015)			
	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Objective 1: **Extend and improve provision of mother-infant health care to 180 remote communities in sub-urban consultation offices with furbishing needs to increase their medical care capacity by 2010.**																												
Activity 1.1: Equip suburban consultation offices according to the established model.																												
Activity 1.2: Provide training and teaching spaces in suburban consultation offices.																												
Activity 1.3: Purchase and distribute basic complementary equipment in 180 suburban consultation offices. (Annex 9).																												
Objective 2: **Reduce low birth weight through care to mothers with LBW risk in Mother-Infant Homes.**																												
Activity 2.1: Prepare the manual of health care to mothers with LBW risk.																												
Activity 2.2: Prepare the manual of health care to mothers with LBW risk in Mother-Infant Homes.																												
Activity 2.3: Teach a workshop with the local government for the implementation of the New Methodology in Mother-Infant Homes.																												
Activity 2.4: Train and teach personnel for the implementation of the Program in Mother-Infant Homes.																												
Objective 3: **Speed up nutritional recovery of LBW infants through mother-child health care in Mother-Infant Homes.**																												

Activity 3.1: Draw-up the manual for health care and nutritional recovery of LBW infants.							
Activity 3.2: Draw-up the manual for health care and nutritional recovery of LBW infants in Mother-Infant Homes.							
Activity 3.3: Carry out Workshops with the Local Government for the implementation of the new methodology in Mother-Infant Homes.							
Activity 3.4: Train and teach personnel for the implementation of the Program in Mother-Infant Homes.							
Objective 4: **Implement the Mother-Infant Homes Program to contribute to the expansion of services and functions in 140 health areas, and create 30 new Mother-Infant Homes until 2015.**							
Activity 4.1 Draft the manual for the organization and functioning of the Mother-Infant Homes.							
Activity 4.2 Draft the model for equipping Mother-Infant Homes.							
Activity 4.3 Purchase and distribute the basic equipment for the 140 existing institutions (Annex 10).							
Activity 4.4 Purchase and distribute the basic equipment for 30 new institutions (Annex 10).							
Activity 4.5 Teach workshop with local government organs for the implementation of the program.							
Objective 5: **Contribute to the reduction of mortality rates in infants of less than 1,500 grams through the design and implementation of a monitoring and evaluation system for comprehensive health care to very low weight infants from 2009.**							
Activity 5.1 Draft the system of vigilance in the national network for health care to very low birth weight infants.							

Activity 5.2 Carry out workshops for the implementation of the system in all the provinces in the country with the participation of the 19 services selected.							
Activity 5.3 Train and teach human resources that will be participating in the system.							
Activity 5.4 Purchase 20 computers and distribute them among the 19 neonatology specialized services and in the national centre.							
Objective 6: **Contribute to the work and performance of the local health care level through the strengthening of the monitoring and assessment of the established program for the municipal health care systems from 2009.**							
Activity 6.1 Update and print supervision and assessment instruments.							
Activity 6.2 Train in the new methodology the teams in charge of supervision and assessment of the municipal health systems and teams in the units under supervision.							
Activity 6.3 Purchase and distribute 30 motorcycles and their spare parts (2 for each province and 2 for the Special Municipality).							
Activity 6.4 Purchase and assign to light vehicles with spare parts for the national level.							

Section 6: Monitoring, Evaluation and Operational Research

To the applicant

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

i) National DTP3 coverage (%)
ii) Number / % of districts achieving ≥ 80% DTP3 coverage[5]
iii) Under five mortality rate (per 1000)

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

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

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

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

Examples of Impact Indicators

- Maternal mortality ratio

Examples of Outcome Indicators

- National measles coverage.
- Proportion of districts with coverage at 80% or above.
- Hib coverage.
- HepB coverage, BCG coverage.
- DTP1-DTP3 drop-out rate.
- Proportion of births attended by skilled health personnel.
- Antenatal care use.
- Vitamin A supplementation rate.

Intervention	Possible indicators
Immunisation	National measles coverage; proportion of districts with coverage at 80% or above; BCG coverage; Polio 3 coverage; Hib coverage; HepB3 coverage.
Maternity care	Antenatal care use; skilled birth attendance; tetanus toxoid 2 or more doses; caesarean section rate; postnatal care.
Family planning	Contraceptive use among women.
Treatment of sick children	oral rehydration therapy and continued feeding for children with diarrhoea; Care seeking for pneumonia; Antibiotic treatment for pneumonia.
Nutrition	Breastfeeding rate; (start on first day, exclusive at 0-3 months, supplements at 6-9 months); vitamin A supplementation rate to children 6-59 months (within last 6 months) and postpartum to mother within 8 weeks.
Water/sanitation	Access to safe water source; adequate sanitary facilities.
Tuberculosis	DOTS treatment coverage (treatment success rate times case detection rate).
Malaria	Children with fever receiving anti-malarials; children sleeping under ITN.
AIDS	% of HIV-positive pregnant women receiving ARVs; PMTCT among pregnant women.

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

To the applicant

- *Please list up to 6 output indicators based on the selected activities in section 5. (Table 6.2).*
- *For all indicators, please give a data source, the baseline value of the indicator and date, a target level and date, as well as a numerator and denominator. Some indicators may have more than one data source (Table 6.1).*

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

Examples of Output Indicators

Indicator	Numerator	Denominator	Data Source
Systematic Supervision	Number of health centres visited at least 6 times in the last year using a quantified checklist	Total number of health centres	Health facility survey
Knowledge of Health Workers	Mean score of health workers in public and NGO health centres on verbal knowledge test including case scenarios		Health facility survey
Drug availability index	Average number of ten selected essential drugs that are in stock in sampled health centres		HMIS & Health facility survey

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[6]	Source[7]	Date of Baseline	Target %	Date for Target
1. National DTP3 coverage (%)	National Statistics Division. MINSAP	98%	National Statistics Division. MINSAP	2007	98%	2015
2. % of municipalities with ≥80% DTP3 coverage	National Statistics Division. MINSAP	89 %	National Statistics Division. MINSAP	2007	95 %	2015
3. Reduction of Low Birth Weight rate	National Statistics Division. MINSAP	5.2	National Statistics Division. MINSAP	2007	‹ 5.0%	2015
4. Mortality rate of infants less than 5 years (per 1000 live births)	National Statistics Division. MINSAP	6.7	National Statistics Division MINSAP	2007	6.0	2015
5.Maternal mortality rate (per 1000 live births)	National Statistics Division. MINSAP	21.3	National Statistics Division MINSAP	2007	10.0	2015
6.% of infants in exclusively mother breastfeeding until 6 months	National Statistics Division. MINSAP	26.4	National Statistics Division. MINSAP	2006	85	2015

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

6.2: Output Indicators

Indicator	Numerator	Denominator	Data Source	Base line Values	Source	Date of Base line	Target	Date for Target
1. Percentage of suburban consultation offices strengthened according to model for furbishing establishments for Primary Health Care (PHC)	Number of suburban consultation offices equipped according to the model for PHC units	Number of suburban consultation offices	Registers and Observation	0%	Monitoring and Assessment Activities	2008	100 %	2015
2. Percentage of mothers with LBW risk that are interned in Maternal homes (MH).	Number of LBW mothers interned in MH institutions	Number of LBW risk mothers	Statistical Records of the program	33%	Survey in Polyclinics and homes	2008	90 %	2015
3. Percentage of LBW infants ≤2,500 g interned in Mother-Infant Homes (MIH) with their mothers	LBW Infants ≤2,500 g interned in MIH with their mothers	Total number of LBW infants	Registers of Municipal health Care Divisions	0%	Registers of Municipal health Care Divisions	2008	100 %	2015
4 Percentage of LBW infants nutritionally recovered in Mother-Infant Homes	LBW Infants that have recovered from nutritional point of view	Total LBW Infants	Registers of Municipal health Care Divisions	0 %	Registers of Municipal health Care Divisions	2008	90 %	2015
5 Percentage of LBW infants nutritionally recovered in Mother-Infant Homes with immunisation coverage.	LBW Infants that have recovered from nutritional point of view and were vaccinated according to immunisation scheme	LBW Infants that have recovered from nutritional point of view	Registers of Municipal health Care Divisions	0 %	Registers of Municipal health Care Divisions	2008	90 %	2015
6. Percentage of very low weight infants in follow up health care through the vigilance system of the network.	Very Low Birth Weight infants being followed-up through the network's vigilance system	Total of infants of very low birth weight.	National Division for Mother-Infant Health Care	0 %	National Division for Mother-Infant Health Care	2008	100 %	2015

7. Percentage of Consultation Offices and Mother Infant Homes visited by the team at the provincial level at least ten times in the year.	Number of Consultation offices and Mother-Infant Homes visited by the provincial team at least 4 times a year.	Total number of Consultation offices and Mother-Infant Homes.	Registers of Municipal health Care Divisions	50 %	Registers of Municipal health Care Divisions	2008	100 %	2015
9. Percentage of health care institutions that meet at least 80% of the supervision and assessment guidelines.	Number of health care institutions that meet at least 80% of the supervision and assessment guidelines.	Number of health care institutions and establishments supervised and assessed.	Registers of Municipal health Care Divisions	50 %	Registers of Municipal health Care Divisions	2008	100 %	2015
10. Percentage of personnel in primary health care, mother-infant health care and neonatology trained through the project.	Primary health care personnel, mother-infant and neonatology health care personnel trained by the project.	Primary health care personnel, mother-infant and neonatology health care personnel participating in the project.	Registers of Municipal health Care Divisions	0 %	Registers of Municipal health Care Divisions	2008	100 %	2015

To the applicant

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

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	National Statistics System	Monthly assessment of the National Immunisation Program	Analysis of the health care situation and Assessment of the program
2. % of municipalities with ≥80% DTP3 coverage	National Statistics System	Monthly assessment of the National Immunisation Program	Analysis of the health care situation and Assessment of the program
3. Reduction of Low Birth Weight rate	National Statistics System	Monthly assessment of the Mother-Infant Program	Analysis of the health care situation and Assessment of the program
4. Mortality rate in infants less than 5 years (per 1000 births)	National Statistics System	Annual Assessment of the Mother-Infant Program Report	Analysis of the health care situation and Assessment of programs
5. Maternal Mortality rate (per 1000 births)	National Statistics System	Annual Assessment of the Mother-Infant Program Report	Analysis of the health care situation and Assessment of programs
6. % of children exclusively breastfeeding until 6 months	National Statistics System	Assessment of the multiple indicators surveys by conglomerate	Analysis of the health care situation and Assessment of programs
Output	**Data collection**	**Data Analysis**	**Use Data**
1. Percentage of suburban consultation offices equipped according to the model for PHC establishments	Registers in polyclinics Monitoring and evaluation program	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services and of the Mother-Infant Health care Program
2. Percentage of LBW mothers interned in MH.	Registers in polyclinics, Mother-Infant Homes and Municipalities	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services and of the Mother-Infant Health care Program

3. Percentage of LBW ≤2,500 g infants interned in MIH with their mothers	Registers in the Municipal and provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services and of the Mother-Infant Health care Program
4. Percentage of low birth weight infants that have nutritionally recovered	Registers in the Municipal and provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services and of the Mother-Infant Health care Program
5. Percentage of low birth weight infants that have nutritionally recovered with immunisation coverage.	Registers in the Municipal and Provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs Monthly assessment of the vigilance system	Assessment of the Primary Health Care Services, of the Mother-Infant Health care Program and of the vigilance and evaluation system
6. Percentage of very low birth weight infants followed-up through the vigilance system of the network.	Registers in the Municipal and provincial Health Care Divisions System of vigilance of the infant of less than 1500 g.	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs Monthly assessment of the vigilance system	Assessment of the Primary Health Care Services, of the Mother-Infant Health care Program and of the vigilance and evaluation system
7. Percentage of Consultation Offices and Mother-Infant Homes visited by the provincial team at least 10 times a year.	Registers in the Municipal and Provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services, of the Mother-Infant Health care Program and of the evaluation system
8. Percentage of health care institutions that meet at least 80% of the criteria for supervision and assessment.	Registers in the Municipal and Provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services, of the Mother-Infant Health care Program and of the evaluation system
9. Percentage of the primary health care personnel, mother-infant health care personnel and neonatology personnel trained through the project.	Registers in the Municipal and Provincial Health Care Divisions	Monthly assessment of Primary Health Care Programs and Mother Infant Health Care Programs	Assessment of the Primary Health Care Services and of the Mother-Infant Health care Program

To the applicant

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

6.4: Strengthening M&E system

The GAVI HSS application will be a considerable contribution to the monitoring and assessment systems as it inherently includes objectives, activities and indicators indispensable for the strengthening of health services, especially in the decentralized periphery services in which it was developed.
Strengthening information and communications systems will have to be strengthened in polyclinics, mother-infant homes, municipal provincial and national health divisions to collect, analyse and use 9 out of the 10 output indicators that are not found within the Information System enforced, but that can be easily incorporated.

6.5: Operational Research

On the conclusion of the Project a final assessment will be made to spread the experience and publicize the results of the Mother-Infant Homes project aiming at the creation of specialized neonatology services for health care to very low birth weight infants.

Section 7: Implementation Arrangements

To the applicant

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

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

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation /	Dr. Longina Ibargollen Negrin National Director for Mother-Infant Health Care
Implementation	The Divisions for Primary Health Care, Mother-Infant Health care and the Extended Immunisations Program will integrate actions in this project to their plan and programs, implementing, evaluating and assessing them with the frequency required.
M&E etc.	Dr. Alicia Izquierdo National Unit of Projects and Donations MINSAP. The National Unit of Projects organizes, coordinates, monitors and evaluates the implementation of this project and the participation of each area and division.
Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	Will be in charge of follow-up, evaluation and assessment of the project's objectives, activities and results.
Mechanism for coordinating GAVI HSS with other system activities and programs	The National Unit of Projects and Donations MINSAP was created to plan, coordinate and evaluate projects, making sure projects complement one another, thus preventing duplicity or leaving aside important areas. The Divisions of Primary Health Care, Mother-Infant care and Extended Immunisations will integrate this project's actions to their plans and programs.

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

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS implementation
Vice minister for Medical Care Dr. Joaquín García Salabarría	Ministry of Public Health	Yes	Manage, evaluate and assess implementation of the project.
Vice minister for Hygiene and Epidemiology Dr. Luis Estruch Rancaño	Ministry of Public Health	Yes	Manage, evaluate and assess implementation of the project
International Relations Division Dr. Néstor Marimón Torres	Ministry of Public Health	Yes	Provide information. Provide technical assistance and assessment. Monitoring implementation.
National Director for Mother-Infant Health Care Dr. Longina Ibargollen Negrín	Ministry of Public Health	Yes	Responsible for the Project's implementation, its management and use of resources. Technical implementation. Evaluation and assessment of project
National Director for Health Care services Dr. Cristina Luna			
National Director of Epidemiology Dr. Manuel Santín Peña			
Head of the National Immunisations Program Dr. Marlen Valcarcel			
Head of the National Unit for Projects and Donations Dr. Alicia Izquierdo	Ministry of Public Health	Yes	Coordinate, evaluate and assess project's implementation. Establish links between the areas involved in the project
Director of International Economic Organizations Lic. Dagmar González Grau	Ministry for Foreign Investment and Economic Cooperation	Yes	Evaluate and approve project.
PAHO/WHO Representative Dr. Lea Guido López	PAHO/WHO	Yes	Revise project strength. Ensure interagency coordination. Monitor and evaluation of process.
Representative of UNICEF Mr. José Juan Ortíz Bru	United Nations Children's Fund. (UNICEF)	Yes	Revise appropriateness of project. Ensure interagency coordination. Monitor and evaluation of the process

To the applicant

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

7.3: Financial management of GAVI HSS support

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country.	Once the project is approved, the Ministry of Public Health will officially request PAHO to channel the funds at no extra administrative charge. As implementation decisions are adopted, an agreement will be signed between PAHO representation in Cuba and the Ministry, through the Vice Ministry for Medical Care, for the channelling of funds to the Ministry of Public Health or to buy supplies, through the purchase division of PAHO national representation.
Mechanism for channelling GAVI HSS funds from central level to the periphery.	Resources will be centrally controlled and distributed to the provinces, municipalities and health areas through direct, specific and exclusive allocation for the project's services and activities as resources are received. Allocation, distribution and use of funds will be centrally controlled. By decision of the Vice ministry of Medical Care and Epidemiology, the divisions for Primary Health Care, Mother-Infant Care and the leadership for the National Immunisation Program (NIP) will prepare a timetable for channelling funds to the services that will benefit from the project based on a previous schedule according to the five-year plan of the corresponding areas.
Mechanism (and responsibility) for budget use and approval	Budget use will be discussed, approved, signed and controlled by the HSCC. Annual reports will be sent according to GAVI's annual reporting Schedule. Reports will be based on the six-monthly reports of the Economy and Planning Divisions of polyclinics, and of municipal, provincial and national levels.
Mechanism for disbursement of GAVI HSS funds	Disembursement of HSS GAVI Project funds shall be through PAHO (either national representation or regional office according to the most beneficial procurement process for each item) always according to the allocation and terms established by the Alliance.
Auditing procedures	Both PAHO and the Ministry of Public Health will supervise and carry out internal and external audits during the development of the project. Both agencies will also make an annual inventory of funds received.

7.4: Procurement mechanisms

To the applicant

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

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

The purchases can be made in Cuba, to companies that commercialize in the country, when there is existence of the necessary merchandise and a good option in quality and price is obtained.
The purchases also can be made to intermediary companies, present in Cuba, but which they buy in another country. For it we must make all the process of quotation, buys and import, through the MINVEC. These processes need the autorization for international purchase from PAHO Headquaters.

7.5: Reporting arrangements

The Ministry of Public Health will write an Annual Progress Report and send it to GAVI on due dates. To this aim, it will collect the information from consultation offices, polyclinics, Mother-Infant homes, municipalities and provinces sent monthly to the national level through the established information channels. Technical assistance from PAHO/WHO will be required and obtained for preparing, analysing and sending the Report.

To the applicant

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

7.6: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Updating refurbishing models for suburban polyclinics	3 months	2009	MINSAP*
2. Prepare manual for care to mothers with LBW risk	3 months	2009	MINSAP
3. Prepare manual for care to mothers with LBW risk in Mother-Infant Homes.	3 months	2009	MINSAP

4. Train staff for implementation of the Program in Mother-Infant Homes.	6 months	2009-2010	MINSAP
5. Prepare manual for care and nutritional recovery of children with LBW	3 months	2009	MINSAP
6. Prepare manual for care and nutritional recovery of children with LBW in Mother-Infant Homes.	3 months	2009	MINSAP
7. Train human resources for the implementation of the program in Mother-Infant Homes.	6 months	2009-2010	MINSAP
8. Prepare manual for the organisation and work of Mother-Infant Homes.	3 months	2009	MINSAP
9. Draft the model to equip Mother-Infant Homes.	3 months	2009	MINSAP
10. Draft the watch system for the national network of care to very low birth weight.	3 months	2009	MINSAP
11. Train human resources that will participate in the system.	6 months	2009	MINSAP
12. Update monitoring and assessment instruments.	6 months	2009	MINSAP
13. Train in the new methodology the teams in charge of monitoring and assessment of the municipal health systems and teams of the units assessed.	6 months	2009	MINSAP

* The Ministry of Public Health (MINSAP), as unique an universal state and national organism for health, is the responsable of all the academics, methodologicals, investigations and services institutions related with health in the country, it centralizes the whole capacity and the technical resources.

Section 8: Costs and Funding for GAVI HSS

To the applicant

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

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

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

8.1: Cost of implementing GAVI HSS activities

Area for support	Cost per year in US$ (,000)								
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	Year 5 of implementation	Year 5 of implementation	TOTAL COSTS
	2008	2009	2010	2011	2012	2013	2014	2015	
Activity costs									
Objective 1		**303 861**	**120 360**	**30 540**					**454 761**
Activity 1.1		**1 000**							**1 000**
Activity 1.2		**2 141**							**2 141**
Activity 1.3		**300 720**	**120 360**	**30 540**					**451 620**
Objective 2		**8 000**	**4 000**	**6 000**					**18 000**
Activity 2.1		**2 000**							**2 000**
Activity 2.2		**2 000**							**2 000**
Activity 2.3		**4 000**							**4 000**
Activity 2.4			**4 000**	**6 000**					**10 000**
Objective 3		**12 000**	**6 000**						**18 000**
Activity 3.1		**2 000**							**2 000**
Activity 3.2		**2 000**							**2 000**
Activity 3.3		**4 000**							**4 000**
Activity 3.4		**4 000**	**6 000**						**10 000**
Objective 4		**505 561**	**444 960**	**247 200**	**247 200**	**247 200**			**1 692 121**
Activity 4.1		**3 000**							**3 000**
Activity 4.2		**2 000**							**2 000**
Activity 4.3		**395 520**	**395 520**	**197 760**	**197 760**	**197 760**			**1 384 320**
Activity 4.4		**98 880**	**49 440**	**49 440**	**49 440**	**49 440**			**296 640**
Activity 4.5		**6 161**							**6 161**

Objective 5		**12 000**	**29 000**						**41 000**
Activity 5.1		**4 000**							**4 000**
Activity 5.2		**6 000**	**5 000**						**11 000**
Activity 5.3		**2 000**	**4 000**						**6 000**
Activity 5.4			**20 000**						**20 000**
Objective 6		**3 000**	**72 818**	**5 000**					**80 818**
Activity 6.1		**3 000**	**3 000**						**6 000**
Activity 6.2			**6 000**	**5 000**					**11 000**
Activity 6.3			**43 818**						**43 818**
Activity 6.4			**20 000**						**20 000**
Suppport Costs *		**5 000**	**5 000**	**5 000**	**18 400**	**14 000**	**10 000**	**7 945**	**65 345**
Management costs		**5 000**	**5 000**	**5 000**	**10 400**	**7 000**	**5 000**	**5 000**	**42 400**
M&E support costs					**8 000**	**7 000**	**5 000**	**2 945**	**22 945**
Technical support									
TOTAL COSTS		**849 422**	**682 138**	**293 740**	**265 600**	**261 200**	**10 000**	**7 945**	**2 370 045**

* Others support costs (Management costs, M&E support costs and Technical support) will be mainly provided by the Ministry of Public Health.

To the applicant

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

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

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

Examples: GAVI HSS country allocation calculation

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

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

8.2: Calculation of GAVI HSS country allocation

GAVI HSS Allocation	Year 1 of implementation 2008	Year 2 of implementation 2009	Year 3 of implementation 2010	Year 4 of implementation 2011	Year 4 of implementation 2012	Year 4 of implementation 2013	Year 4 of implementation 2014	Year 4 of implementation 2015	**TOTAL FUNDS**
Birth cohort	116,456	121,206	125,706	130,506	135,500	140,100	145 000	150 000	**948 018**
Allocation per newborn		2.5	2.5	2.5	2.5	2.5	2.5	2.5	**2.5**
Annual allocation		285,515	286,765	290,515	295,000	300,250	306,250	312,500	**2 370 045**

Source and date of GNI and birth cohort information:

GNI: 1,170 $US per capita
Birth cohort: 116,456
Total Other:

To the applicant:
Note: Table 8.3 is not a compulsory table.

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

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

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

The budget of the Cuban National Health Care System is designed and implemented in a decentralized manner and with a system approach. It comprehensively includes all services and programs.

No vertical budget for independent Programs and Services is allocated.

Sources of funding are almost all from the state budget (> 98%), though some foreign donor resources and international projects are mobilised for specific areas, such as, Primary Health Care, Mother-infant care, Immunisations, HIV/AIDS, and TB among others.

Funding Sources	Allocation per year (US$)								
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	Year 5 of implementation	Year 6of implementation	Year 7 of implementation	TOTAL FUNDS
	2008	2009	2010	2011	2012	2013	2014	2015	
GAVI		303 015	314 265	326 265	338 750	350 250	362 500	375 000	2 370 045
Government		1 200000	2 000000	2 200000	2 400000	2 500000	2 600000	2 700 000	15 600 000
Donor 1.									
Donor 2.									
Total Other									
TOTAL FUNDING		1 503015	2 314265	2 526265	2 738750	2 850250	2 962500	3 075 000	17 970 045

Source of information on funding sources:

GAVI: .....

Government: .....

Donor 1: .....

Donor 2: .....

Donor 3: .....

Total other: .....

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

To the applicant:

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

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

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan: Cuban Public Health Projections 2015	Yes	2006-2015	3
Primary Health Care Projections [8]	Yes	2007	4
The Mother and Child Health Program Projections [9]	Yes	2007	5
Low Weigth Born Reduction Program and Infertility Care Program	Yes	2007	6
Maternal Homes Assessment and Maternal and Child Homes Founds [8]	Yes	2007	7
Health Sector Coordination Committee Minutes signed by the President.	Yes	2008	8
Module of basic equipment to complete in outlying medical offices	Yes	2008	9
Module of basic equipment for Infantile Maternal Homes of 6 beds	Yes	2008	10
Distribution of Maternal Homes for provinces and municipalities	Yes	2008	11
Index of low weight born in connection with the Maternal Homes	Yes	2008	12
National Immunisations Program. Five Year Plan Cuba, 2006 to 2011	Yes	2006-2011	13
Country Multiyear Plan	Yes	2008	14
Recent health sector assessment on immunisation programme	Yes	2007	15

[8] If available – and if not, the National Immunisation Plan plus Financial Sustainability Plan
[9] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application