*The GAVI Alliance*

# Annual Progress Report 2013

Submitted by

## the Government of

## *Democratic Republic of the Congo (Kinshasa)*

Reporting on year: **2013**

Requesting for support year: **2015**

Date of submission: **May 15, 2014**

**Deadline for submission: May 22, 2014**

Please submit the 2013 annual progress report by using the online platform: https://AppsPortal.gavialliance.org/PDExtranet

For any questions, please contact: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

**Note:** *You are encouraged to use previous APRs and support requests approved by GAVI as reference documents. Electronic copies of the previous APRs and approved support proposals are available at http://www.gavialliance.org/country/*

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

**GAVI ALLIANCE**
**GRANT CLAUSES AND CONDITIONS**

**FUNDING USED SOLELY FOR APPROVED PROGRAMS**

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

**AMENDMENT TO THE APPLICATION**

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

**RETURN OF FUNDS**

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

**SUSPENSION/TERMINATION**

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

**ANTICORRUPTION**

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

**AUDITS AND RECORDS**

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

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

**CONFIRMATION OF LEGAL VALIDITY**

The Country and the signatories for the government confirm that this application is accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programs described in this application.

**CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY**

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

**Use of commercial bank accounts**

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support. The Country confirms that it will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

**ARBITRATION**

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

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

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

***By filling this APR the Country will inform GAVI about:***

*Accomplishments using GAVI resources in the past year*

*Important problems that were encountered and how the country has tried to overcome them.*

*Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners*

*Requesting more funds that had been approved in previous application for VSS/NVS/HSS, but have not yet been released*

*How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.*

# 1. Application Specification

Reporting on year: **2013**

Requesting for support year: **2015**

## 1.1. NVS & Injection Supplies support

| Type of Support | Current Vaccine | Preferred presentation | Active until |
|---|---|---|---|
| Routine New Vaccines Support | DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | DTP-HepB-Hib, 10 dose(s) per vial, LIQUID | 2015 |
| Routine New Vaccines Support | Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 2015 |
| Routine New Vaccines Support | Yellow Fever, 5 dose(s) per vial, FREEZE-DRIED | Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED | 2015 |

**DTP-HepB-Hib (Pentavalent)** vaccine: based on your country's current preferences, vaccine is available through UNICEF in liquid form in single dose and 10 dose vials and in liquid/freeze-dried form in two dose vials to be used with a three injection schedule Other presentations have also been preselected by the WHO and the complete list can be consulted on the WHO web site, however, the availability of each product must

be specifically confirmed.

### 1.2. Program Extension

No NVS eligible for extension this year.

### 1.3. VSS, HSS, CSO

| Type of Support | Reporting fund utilization in 2013 | Request for Approval of | Eligible For 2013 VSS reward |
|---|---|---|---|
| VSS | No | next segment: N/A | Yes |
| HSS | Yes | next segment of HSS allocation: N/A | N/A |
| Type B CSO | Yes | Extension of Type B CSO support by decision of the GAVI Alliance Board in July 2013: N/A | N/A |
| VIG | No | N/A | N/A |
| CSO | Yes | N/A | N/A |
| Product Switch Grant | Yes | | N/A |

VIG: GAVI Vaccine Introduction Grant; COS: Operational support for campaign

### 1.4. Previous Monitoring IRC Report

The IRC Annual Progress Report (APR) for the year 2012 is available here. It is also available in French here.

## 2. Signatures

### 2.1. Government Signatures Page for all GAVI Support (VSS, INS, NVS, HSS, CSO)

By signing this page, the Government of the Democratic Republic of the Congo (Kinshasa) hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the government of the Democratic Republic of the Congo (Kinshasa).

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & the Minister Finance or their authorized representative.

| Ministry of Health (or their authorized representative) | | Minister of Finance (or or their authorized representative) | |
|---|---|---|---|
| **Name** | Dr. Félix KABANGE NUMBI MUKWAMPA | **Name** | Mr. Patrice KITEBI KIBOL MVUL |
| **Date** | | **Date** | |
| **Signature** | | **Signature** | |

*This report has been compiled by (these persons may be contacted in case the GAVI Secretariat has queries on this document):*

| Full name | Title | Telephone | Email address |
|---|---|---|---|
| Dr. Hypolite KALAMBAY | DEP Director | +243817005463 | hkalambay@yahoo.fr |
| Dr. Audry MULUMBA W.K. | Director of EVP | +243998363739 or +243816179384 | audrywakamba@gmail.com |

| | | | |
|---|---|---|---|
| Dr. Guylain KAYA MUTENDA SHERIA | Adjunct EVP Director | +243815678166 | guylainkaya@gmai.com |
| Dr. Norbert YOLOYOLO | Technical Division Head | +243819319945 | norroyolo@gmail.com |
| Dr. Guillaume NGOIE MWAMBA | Support Division Head | +243997046789 or +243817975023 | guillaumengoiemwamba@gmail.com |
| Mr. Serge KABEYA KATOMPA | EVP Logistics Division Head | +243999993087 | sergekabeyakatompa@yahoo.fr |
| Mr. Benjamain MATATA | EVP Finance Service Head | +243998298097 | benjmatata2001@yahoo.fr |
| Dr. Bertin LORA | EVP Monitoring and Evaluation Department Head | +243816682386 OR +243998947449 | lorabertin@yahoo.fr |
| Dr. Nestor MUKINAY | GAVI HSS Project Manager | +243998130746 | nestordizal@yahoo.fr |
| Dr. Thomas KATABA | DEP Health Expert | +243991097175 | katabathomas@gmail.com |
| Dr. Coulibaly Tiekoura | DRC WHO DVI Focal Point | +243817006419 | coulibalyt@cd.afro.who.int |
| Dr. Rija Andriamihantanirina | Vaccination Manager UNICEF DRC | +243817107074 | andriamihantanirina@unicef.org |
| Ms. Yolande VUO MASEMBE | Routine Vaccination Officer WHO DRC | +243817150246 | masembey@who.int |
| Dr. Emmanuel NOMO | Polio Team Head UNICEF DRC | +243818803982 | enomo@unicef.org |
| Ms. Fatuma KAWENDE | DRC EVP Administrative and Finance Division Head | +243810036483 | kawendef@yahoo.fr |
| Engr. Pascal MUKENYI | EVP Data Manager | +243999999409 or +243818555867 | pmukenyi@yahoo.fr or pmukenyi@gmail.com |
| Dr. Elisabeth MUKAMBA MUSENGA | Department Head DRC Routine EVP | +243999992735 | elisabethmukamba@gmail.com |
| Dr. Ado BWAKA | BMGF | +243824920483 | adobwaka@yahoo.com |
| Dr. Héléne MAMBU-ma-DISU | Sabin Vaccine Institute | +243824920483 | helene.mambu@sabin.org |
| Dr. Stanislas MAKONGOTE | SVA/EVP Department Head | +243993531700 | paatermakongote@gmail.com |
| Mr. Nahari NDOLDE | UNICEF | +243817008509 | nndolde@unicef.org |
| Dr. Diallo Ibrahima Telly | UNICEF | +243819895119 | itellydiallo@yahoo.fr |

## 2.2. ICC Signatures Page

*If the country is reporting on Vaccination Services (VSS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports*

**In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload two copies of the attached documents section the signatures pages signed by committee members, one for HSCC signatures and one for ICC signatures.**

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

### 2.2.1. ICC Report Endorsement

We, the undersigned members of the vaccination Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Dr. Joseph Waogodo CABORE/Representative | WHO | | |
| Dr. Félix KABANGE NUMBI MUKWAMPA/Minister of Health | Government | | |
| Ms. Barbara BENTEIN/Representative | UNICEF | | |
| Dr. Diana Patman/Health Program Head | USAID | | |
| Mr. Ambroise Tshimbalanga/President | Rotary International | | |
| Dr. Audry MULUMBA/EVP Dir. | Ministry of Health | | |

The ICC may send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from partners:

Comments from the Regional Working Group:

## 2.3. HSCC Signatures Page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Dr. MUKENGESHAYI KUPA, Dr. Joseph Waodogo CABORE, Ms. Barbara BENTEIN, Dr. Diana Patman, Dr. Hyppolite KALAMBAY, endorse this report on the Health Systems Strengthening Program. Signature of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|
| Dr. Joseph Waogodo CABORE/Representative | WHO | | |
| Dr. MUKENGESHAYI KUPA/Secretary General for Health | Government | | |

| | | | |
|---|---|---|---|
| Dr. Jean Pierre Lokonga/MPN | WHO | | |
| Ms. Barbara BENTEIN/Representative | UNICEF | | |
| Dr. Diana Patman/Health Program Head | USAID | | |
| Dr. Hypolite Kalambay/DEP Director | Government | | |

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

## 2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

The present report was prepared in consultation with the CSO representatives who participate in the national level coordination mechanisms HSCC or equivalent and IACC) and the persons responsible for listing the CSO (for type A support), and also with people who receive GAVI financial support to help implement the GAVI HSS proposal or the cMYP (for type B support).

### 2.4.1. People Responsible for Preparation of the Report on CSO Support

This report on the GAVI Alliance CSO Support has been completed by:

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|

### 2.4.2. Endorsement of the Report on CSO Support

We, the undersigned members of the National Health Sector Coordinating Committee (or equivalent committee), endorse this report on the GAVI Alliance CSO Support.

| Name/Title | Agency/Organization | Signature | Date |
|---|---|---|---|
| Dr. MUKENGESHAYI KUPA/Secretary General for Health | Government | | |
| Dr. Hypolite Kalambay/DEP Director | Government | | |

| | | | |
|---|---|---|---|
| Ms. Barbara BENTEIN/Representative | UNICEF | | |

Signature of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

## 3. Table of Contents

*This APR reports on the activities conducted by the Democratic Republic of the Congo (Kinshasa) between January – December 2013 and specifies the requests for the period of January – December 2015*

**Sections**

## 4. Baseline and Annual Targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use the maximum wastage rates presented for information in the attachment **Wastage Rate Table** to the guidelines for support requests. Please describe the reference wastage rate for the pentavalent vaccine available in 10-dose vials.

| Number | Achievements Conforming to the Joint WHO/UNICEF Report | | Targets (preferred presentation) | | | |
|---|---|---|---|---|---|---|
| | 2013 | | 2014 | | 2015 | |
| | Original approved target according to Decision Letter | Reported | Original approved target according to Decision Letter | Current estimation | Previous estimates in 2013 | Current estimation |
| **Total number of births** | 3,458,132 | 3,458,132 | 3,561,876 | 3,561,876 | 3,668,732 | 3,668,732 |
| **Total infants' deaths** | 440,912 | 440,912 | 454,139 | 454,139 | 467,763 | 467,763 |
| **Total surviving infants** | 3017220 | 3,017,220 | 3,107,737 | 3,107,737 | 3,200,969 | 3,200,969 |
| **Total pregnant women** | 3,458,132 | 3,458,132 | 3,561,876 | 3,561,876 | 3,668,732 | 3,668,732 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Number of infants vaccinated (to be vaccinated) with BCG** | 3,181,481 | 3,301,766 | 3,348,163 | 3,383,782 | 3,485,296 | 3,485,296 |
| **BCG coverage** | 92% | 95% | 94% | 95% | 95% | 95% |
| **Number of infants vaccinated (to be vaccinated) with OPV3** | 2,715,498 | 2,715,636 | 2,859,118 | 2,796,963 | 3,008,911 | 2,880,872 |
| **OPV3 coverage** | 90% | 90% | 92% | 90% | 94% | 90% |
| **Number of infants vaccinated (to be vaccinated) with DTP1** | 2,775,843 | 2,930,262 | 2,921,273 | 2,952,350 | 3,040,920 | 3,040,920 |
| **Number of infants vaccinated (to be vaccinated) with DTP3** | 2,715,498 | 2,728,848 | 2,859,118 | 2,796,963 | 3,008,911 | 2,880,872 |
| **DTP3 coverage** | 90% | 90% | 92% | 90% | 94% | 90% |
| **Wastage[1] rate in base-year and planned thereafter (%) for DTP** | 10 | 6 | 10 | 10 | 10 | 10 |
| **Wastage[1] factor in base-year and planned thereafter for DTP** | 1.11 | 1.06 | 1.11 | 1.11 | 1.11 | 1.11 |
| **Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib** | 2,382,899 | 2,930,262 | 2,921,273 | 2,952,350 | 3,040,920 | 3,040,920 |
| **Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib** | 2,382,899 | 2,728,848 | 2,921,273 | 2,796,963 | 3,008,911 | 2,880,872 |
| **DTP-HepB-Hib coverage** | 79% | 90% | 94% | 90% | 94% | 90% |
| **Wastage[1] rate in base-year and planned thereafter (%)** | 25 | 6 | 5 | 10 | 5 | 10 |
| **Wastage rate [1] in base-year and planned thereafter (%)** | 1.33 | 1.06 | 1.05 | 1.11 | 1.05 | 1.11 |
| **Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID** | 25% | 0% | 25% | 25% | 25% | 25% |
| **Number of infants vaccinated (to be vaccinated) with Yellow Fever** | 2,467,001 | 2,250,537 | 2,796,963 | 2,796,963 | 2,976,901 | 2,880,872 |
| **Yellow Fever coverage** | 82% | 75% | 90% | 90% | 93% | 90% |
| **Wastage[1] rate in base-year and planned thereafter (%)** | 18 | 17 | 40 | 18 | 15 | 15 |
| **Wastage rate [1] in base-year and planned thereafter (%)** | 1.22 | 1.2 | 1.67 | 1.22 | 1.18 | 1.18 |
| **Maximum wastage rate value for Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED** | 10% | 40% | 10% | 40% | 10% | 40% |
| **Number of infants vaccinated (to be vaccinated) with 1st dose of Pneumococcal (PCV13)** | 1,418,300 | 1,943,803 | 2,921,273 | 2,952,350 | 3,040,920 | 3,040,920 |
| **Number of infants vaccinated (to be vaccinated) with 3rd dose of Pneumococcal (PCV13)** | 1,418,300 | 1,328,397 | 2,921,273 | 2,796,963 | 3,008,911 | 2,880,872 |
| **Pneumococcal (PCV13) coverage** | 47% | 44% | 94% | 90% | 94% | 90% |
| **Wastage[1] rate in base-year and planned thereafter (%)** | 5 | 3 | 5 | 5 | 5 | 5 |
| **Wastage rate [1] in base-year and planned** | 1.05 | 1.03 | 1.05 | 1.05 | 1.05 | 1.05 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **thereafter (%)** | | | | | | |
| **Maximum wastage rate value for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID** | 5% | 5% | 5% | 5% | 5% | 5% |
| **Number of infants vaccinated (to be vaccinated) with 1st dose of Measles** | 2,624,982 | 2,656,276 | 2,796,963 | 2,796,963 | 2,976,901 | 2,880,872 |
| **Measles coverage** | 87% | 88% | 90% | 90% | 93% | 90% |
| **Pregnant women vaccinated with TT+** | 3,008,575 | 3,004,766 | 3,205,688 | 3,205,688 | 3,411,921 | 15 |
| **TT+ coverage** | 87% | 87% | 90% | 90% | 93% | 0% |
| **Vit A supplement to mothers within 6 weeks from delivery** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Vit A supplement to infants after 6 months** | 0 | 15,269,432 | 0 | 15,048,926 | 0 | 15,500,394 |
| **Annual DTP Drop out rate [ ( DTP1 – DTP3 ) / DTP1 ] x 100** | 2% | 7% | 2% | 5% | 1% | 5% |

* Number of infants vaccinated out of total births ** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [ ( A – B ) / A ] x 100, whereby A = the number of doses distributed for use according to procurement records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

# 5. General Program Management Component

## 5.1. Updated Baseline and Annual Targets

**Note:** Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2013 must be consistent with those that the country sent in the **WHO/UNICEF Joint Reporting Form (JRF) for reporting on 2013 vaccination activities**. The numbers for 2014 – 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in a new GAVI support application for or in the cMYP.

In the space below, please provide justification for those numbers in this APR that are different from those in the reference documents.

- Justification for any changes in births

In March 2013, the population was estimated at 80,501,926 based on the 2012 population increased by 3% growth rate. In April 2013, the operational population coming from the micro planning and used by the vaccination service is estimated at 86,453,301 and habitants. These numbers were approved by each province and by the CNC centrally.
Thus, the population for life births went from 3,126,288 in 2012 to 3,460,538 in 2013. (Attached are the Table of New Populations confirmed 2013 and the report of the CNC driving these population data.)

- Justification for any changes in surviving infants

In March 2013, the population was estimated at 80,501,926 based on the 2012 population increased by 3% growth rate. In April 2013, the operational population coming from the micro planning and used by

the vaccination surface is estimated at 86,453,301 and habitants. These numbers were approved by each province and by the CNC centrally.
Thus the population of surviving infants went from 2,727,687 in 2012 to 3,019,320 in 2013. (Attached are the Table of New Populations confirmed 2013 and the report of the CNC driving these population data.)

- Justification for any changes in objectives by vaccine. **Please note that objectives that surpass the previous years' results by more than 10 % must be justified.**

No change in the objectives during 2013 The change in the targets for all antigens following 2013 no longer conforms to the new cMYP (2013-2015) which was revised in August 2012. The objectives set in 2013 reflected the official results achieved in 2012.

- the validation of the data reported for 2012 shifted the vaccination coverage obtained for BCG from 95.4% to 88.1%, DTP 1 from 99% to 99%, DTP3 from 91.7% 88.5% OPV3 from 91.3% to 88.7% measles from 91.5% 84.1%, yellow fever from 84.5% to 76.1%, pneumococcus 3 from 27.1% to 26.5%, TT 2+ from 85.5% 86.2% (see attached validation report).

- All projections in 2013 were made from official estimates.

- Justification for any changes in **wastage rate by vaccine**

The country adopted the 10 dose pentavalent vaccine (DTP-hep B-HIB) instead of single-dose vials. Which explains the change of Wastage Rate for this antigen to 10% instead of 5%.

## 5.2. Vaccination Achievements in 2013

5.2.1. Please comment on vaccination program achievements in comparison to targets (as stated in last year's APR), the key major activities conducted and the challenges faced in 2013 and how these were addressed:

The objectives set were reached for BCG, DTP-HepB-Hib 1 and measles whereas the vaccination coverage for DTP-HepB-Hib 3, OPV 3 TT 2+, yellow fever and PCV-13 remained below targets set in 2013.

Generally, vaccination coverages achieved in 2013 are below those from 2012 for nearly all antigens, except BCG (95.45% in 2012 and 95.47% in 2013), PCV-13 (3) (44% in 2013 compared to 27.4% in 2012) and TT 2+ (87% in 2013 and 85.47% in 2012). The performance for the provinces were lower in 2013 except for the provinces of Bas Congo, Kasaï Oriental, Nord Kivu and Province Orientale for DTP-HepB-Hib 3. Nationally, the reported vaccination coverages 90.4% in 2013 wheras it was 91.7% for DTP-HepB-Hib 3 in 2012.

Out of concern for improving data quality, we conducted a validation in 2013 of reported administrative data which led to an adjustment of the vaccination coverages to 87.2% for DTP-HepB-Hib 3 compared to 95.4% and 87.3% for OPV 3 compared to 90% and 87.8% for measles compared to 88%.

Note that in 2013, all the provinces reached a DTP-HepB-Hib 3 vaccination coverage over 80%.

The difference in vaccination coverage observed between measles and yellow fever is related to stock outages encountered for yellow fever (four months centrally and 28 days in the provinces).

As it relates to PCV-13 (3), the coverage is different from that for DTP-HepB-Hib 3 and OPV 3 because of the progressive introduction of PCV 13 in the provinces (Kasai Occidental, Kasai Oriental and Maniema provinces in April 2013; Katanga province in August; and Equateur province and Province Orientale in September 2013).

5.2.2. If targets were not reached, please comment on the reasons for not doing so:

The country has been working on the data quality improvement process since 2012. The 2013 vaccination coverage objectives were set based on administrative coverages reached in 2012. At the outcome of the data validation exercise in 2013, it was found that the vaccination coverages reached were below the targets set for most of the antigens. Note that in 2013 the country experienced a yellow fever stock outage and that this affected the central level (four months) and the provinces (28 days).

As for the new PCV-13 vaccine, the country chose a progressive introduction: (Kasai Occidental, Kasai Oriental and Maniema provinces in April 2013; Katanga province in August 2013; and Equateur province and

Province Orientale in September 2013).

## 5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. During the last five years, were sex-disaggregated data on vaccination service access available in your country from administrative data sources and/or studies on DTP3 coverage?

If yes, please report the latest data available and the year that is it from.

| Data Source | Reference Year for Estimates | DTP3 Coverage Estimate | |
|---|---|---|---|
| | | Boys | Girls |
| Not available | Not available | Not available | Not available |

5.3.2. How have you been using the above data to address gender-related barriers to vaccination access?

Not available

5.3.3. If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine vaccination reporting? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering vaccination services (for example, mothers not having access to such services, the sex of service providers, etc) been addressed programmatically? (For further information on these gender specific obstacles, please refer to the GAVI file “Gender and Vaccination” on the page http://www.gavialliance.org/fr/librairie/)

Not available

## 5.4. Data assessments

5.4.1. Please comment on any discrepancies between the vaccination coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF estimate of national Vaccination coverage and the official country estimate differ).

The administrative data from 2013 are validated by the IACC and the results of the DHS II survey done in 2013 are expected in 2014.

Please note that the WHO UNICEF estimates for 2013 will only be available in July 2014 and may entail retrospective changes to the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

External evaluation of the EVP was done in April and May 2012 and took the different levels of the country’s health system. This evaluation had formulated the following recommendations related to data quality improvement:

- Provide routine training supervision at the intermediate level;
- Provide information feedback at all levels;
- Make the EVP training plan implementation effective at all levels;
- Support operational level planning and implementation for the RED approach;
- Train/Retrain EVP data managers on the DVD-MT and SMT tool;
- Provide the health centers with disease reporting media and AFP and measles sampling kits;

- Make directives/policies available to the HC covering aspects of injection safety;
- Support all the Health Zones in implementing the DQS
- Implement the preliminaries for new vaccine (NV) introduction at all levels keeping in consideration the observations made by the review concerning NV introduction;
- Strengthen the technical (design, data collection and coordination), hardware and financial abilities in health communication;
- Establish regular meetings of the IACC expanded to other affected partners
- Have the community participate in the planning of vaccination sessions in the health areas in order for them to be able to play a significant role in the community level situation analysis;
- Institute systematic monthly EVP monitoring;
- Regularly perform data processing (statistical and graphical analysis, interpretation) to take timely corrective measures;
- Encourage the use of all EVP antigens during vaccination sessions;
- Strengthen the capabilities for monitoring the AEFV: training, supervision and awareness raising on systematic notification;
- Provide training of RECO on their role which should not be limited to mass campaign activities but instead continuously directed to routine activities;

Provide advocacy with the Ministry of Health for the revitalization of Health Zones, since the Health Zone is the operational unit for implementing the National Health Plan (NHP).

5.4.3. Please describe any activities undertaken to improve administrative data systems from 2011 to the present.

- Training of trainers for intermediate level managers in MLM in all the provinces in 2013;

-Holding central level and provincial data validation meetings in 2013;

-Training of trainers on evaluation of vaccination data quality with the support of IVD/IST center in November 2011, with application in the provinces of Bas-Congo, Bandundu, Equateur, Katanga, Kinshasa, Province Orientale, Nord Kivu and Sud Kivu.

-Vaccination data quality self-evaluation exercises have been done:

- in 2011 in 23 Health Zones
- in 2012 in 20 Health Zones
- in 2013 in 25 Health Zones

-Monthly monitoring meetings were organized in the Health Zones in order to analyze health area data and take necessary corrective measures;

-Quarterly reviews were organized in branches:

- 46 completed of 176 planned reviews in 2011.
- 86 completed of 176 planned reviews in 2012.

-Semiannual reviews were organized at coordination levels:

- 11 completed of 22 planned reviews in 2010 and
- 11 completed of 22 planned reviews in 2011 for analysis of health zone/branch data and for taking necessary corrective measures

- 13 done of 22 planned reviews in 2012

-Each year a midcourse review and an annual review are organized at the central level

-Monthly data validation meetings are held at the central level and in the provinces since 2011.

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

**Vaccination data quality improvement:** It's a matter of having monthly data monitoring meetings at the health area level in order to analyze the data and use them for action before sending them to the central office of the health zone and monthly vaccination data validation meetings which will be held during monitoring meetings at the CHZO before sending data to the branches. They will then need to hold health zone data validation meetings before sending the data to the coordinations and the coordinations before sending the data to the central level. The coordinations will also need to organize monthly data validation meetings before sending the data to the regional level. Each level will be periodically supported in the data validation missions by the next higher hierarchical level by field visits. In order to measure progress in data quality improvement, are DQS will need to be done each month at the health zone level by the HZMT and in the health zones will be supported by the intermediate level teams at least once per quarter. However, the central level will accompany the intermediate level in strengthening the capacities of the leaders of health zones in performing DQS associated with the correction plan which will need to be monitored. Other data quality evaluation methods can also be conducted from the central level to the provinces/branches/health zone (for example CDC Method). In each branch, two to three health zones can be chosen for conducting cluster vaccination coverage surveys or LQAS for confirming the routine data.

This data quality improvement will require the use of DVT-MT in all the HZ which will make use of a tool for transmitting data to the intermediate and central levels, and also providing office supplies for proper archiving and training of data managers from the branches This data quality can only be guaranteed by continuous availability of data collection tools including vaccination cards. Additionally, a closer monitoring of planned activities, vaccination data and vaccine management will be done with the weekly rhythm by the EVP Management and the vaccination support partners during teleconferences with each province and regional level (AFRO WHO, UNICEF WCARO) and internationally (GAVI Alliance Geneva, etc.) at the time of monitoring the implementation of the 2014 OAP.

## 5.5. Overall Expenditures and Financing for Vaccination

The purpose of Table 2 is to guide GAVI understanding of the broad trends in vaccination program expenditures and financial flows. Please fill in the table using US$.

| | | |
|---|---|---|
| **Exchange rate used** | 1 US$ = 930 | Only enter the exchange rate; do not list the name of the local currency |

**Table 5.5a:** Overall Expenditure and Financing for Vaccination from all sources (Government and donors) in US$

| Expenditures by Category | Expenditure Year 2011 | Funding source | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Country | GAVI | UNICEF | WHO | World Bank | USAID/PROSANI and MCHIP | Rotary and Sabin |
| Traditional Vaccines* | 1,858,009 | 1,000,000 | 0 | 858,009 | 0 | 0 | 0 | 0 |
| New and underused Vaccines** | 48,426,518 | 2,727,193 | 45,699,325 | 0 | 0 | 0 | 0 | 0 |
| Injection supplies (both AD syringes and syringes other than ADs) | 5,442,748 | 0 | 4,519,713 | 583,035 | 0 | 0 | 340,000 | 0 |
| Cold chain equipment | 1,952,040 | 0 | 0 | 1,395,355 | 0 | 0 | 556,685 | 0 |
| Staff | 837,826 | 837,826 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other routine recurrent costs | 19,157,630 | 434,782 | 1,566,413 | 3,566,662 | 5,091,192 | 6,029,274 | 1,858,020 | 611,287 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Other capital costs | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Campaigns costs | 31,351,845 | 1,504,860 | 1,997,344 | 17,239,727 | 10,538,056 | 0 | 71,858 | 0 |
| Yellow fever campaign in three health zones (Kamana, Lubao and Ludimbi Lukula) in Kasai Oriental | | 703,000 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| Total Expenditures for Vaccination | 109,026,616 | | | | | | | |
| | | | | | | | | |
| Total Government Health | | 7,207,661 | 53,782,795 | 23,642,788 | 15,629,248 | 6,029,274 | 2,826,563 | 611,287 |

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there is no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2014 and 2015

Not applicable for 2013, but for the 2014-2015 operating period the DRC Government has agreed to allocate funds for purchasing traditional vaccines for an amount of $6,936,025 in 2014 and for 2015 we are waiting for passage of the budget law for the 2015 operating period.

## 5.6. Financial management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **Yes, fully implemented**

**If Yes,** briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

| Action plan from Aide Mémoire | Implemented? |
|---|---|
| Planning, budgeting and coordination | Yes |
| Funds disbursement | Yes |
| Awarding procurement contracts | Yes |
| Internal audit | Yes |
| External audit | Yes |
| Arrangements for bank accounts | Yes |

If the above table shows the action plan from the Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented.

The above table, in the implementation part shows the progress accomplished against requirements and conditions agreed upon in the Aide-Memoire. Application of the recommendations is already effective in the Public Health Ministry structures.

The following have been implemented:

1. Planning, budgeting and coordination

- The Ministry of Public Health Management Support Cell (MSC) and AGEFIN are operational;

- The KPMG fiduciary is functional across the country;

- The budgeted annual plan was prepared (OAP 2013);

2. Funds disbursement

- A bank account specifically for GAVI funds is open at RAWBANK;

3. Awarding Procurement Contracts

- The MST organizes awarding procurement contracts;

4. Internal Audit

- The internal audit assignments are organized quarterly in the EVP structures and supported by a report.

5. External audit

- The external audit was conducted in 2012 (July and August) by STRONG. A management improvement plan for the program was developed and is implemented following the formulated recommendations.

6. Bank accounts

- The GAVI bank account was created according to the instructions contained in the Aide-Memoire

If none has been implemented, briefly state below why those requirements and conditions were not met.

N/A

### 5.7. Inter-Agency Coordinating Committee

How many times did the ICC meet in 2013? **5**

Please attach the minutes (**Document 4**) from the IACC meeting in 2014 which endorsed this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1. Updated Baseline and Annual Targets to 5.5 Overall Expenditures and Financing for Vaccination.

**Main concerns/recommendations from the 2013 IACC meetings:**

- Provide tracking of reproduction tools before introducing PCV 13 in the three remaining provinces (Equateur, Katanga and

Province Orientale).

- Release directives for the organization of responses to cases of MNT.
- With the various partners harmonize the financial data for their support for the first half of 2013
- Hold a joint EVP-WHO-UNICEF meeting with the communication subcommission for harmonizing the communication financing data for the campaigns
- Get information about BCG stock outages in the HZ. Inform UNICEF about the provinces which have BCG stock outages.
- Henceforth, the IACC presentations will need to be prepared by commissions
- Improve the OAP per the observations made and use official vaccination coverage in all documents
- Insert all the data enrichments during the meeting and consider the improvement of the SVA quality
- Update cold chain inventories in anticipation of organizing future campaigns (measles and polio)
- Insert the workshop for preparation of the 2012 annual report of the documentation for the polio eradication process into the activities for the second half of 2013

- A team will need to work on updating the population figures for 2013
- Prepare official delivery of the 2013 OAP to the partners by the Minister of Health

Are any Civil Society Organisations members of the ICC? **Yes**

**If Yes, which ones?**

| List the CSO member organizations belonging to the ICC: |
|---|
| SANRU |
| CNOS |
| ROTARY |
| Red Cross |

## 5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EVP program for 2014 to 2015?

**General Objective**

- Contribute to the reduction of morbidity and mortality related to vaccination avoidable diseases

**Specific objectives**

By end of 2014:

- Reduce the proportion of children not vaccinated with DTP-HepB-Hib 3 and OPV 3 to under 10%.
- Bring the proportion of HZ with satisfactory data quality indicators from 26 to 58% (FV: 100% et IQ: 80%)
- Bring the availability rate for quality vaccines and injection supplies from 90 to 100% in the country's 516 health zones
- At the service delivery level bring the coverage of functional cold chain equipment from 29 to 50%
- Maintain the eradication in DRC of wild and vaccine derived polio virus
- Reduce the unvaccinated proportion in each health zone by at least 5% during the SVA
- Bring the HZ which have incorporated community based monitoring from 0 to 50%
- Reach the indicators required at the global level in connection with case by case monitoring for AFP, measles, yellow fever and MNT
- Reach the performance criteria for germ detection at the sentinel sites
- Reduce the proportion of parents and guardians of children under one year old who have not completed the vaccination schedule for their children from 10% to under 10%.
- Increase the government funds disbursement rate from 42% to at least 80%

**Vaccination Coverage Targets 2014**

The projection for the 2014 vaccination coverage targets based on the administrative data results obtained in 2013 is as

follows:

**Vaccination Coverage Objectives for Traditional Vaccines**

**Antigen Vaccination Coverage Target 2014 Vaccination Coverage Target 2015**
BCG95%95%VAT2+90%90%VAR90%90%VPO (1)95%95%VPO (390%90%

**Vaccination Coverage Objectives for Underused and New Vaccines**

**Antigen Vaccination Coverage Target 2014 Vaccination Coverage Target 2015**
VAA 90% 90%DTC-HepB-Hib (1) 95%95%DTC-HepB-Hib (3) 90%90%Pneumo-13 (1) 95%95%Pneumo-13(3) 90%90%

In order to reach the set targets, the following main activities will be implemented by component.

**PERSISTENCE OF LARGE NUMBER OF UNVACCINATED OR UNDER VACCINATED CHILDREN**

**(290,273 children unvaccinated against DTP-HepB-Hib 3)**

- Financially and technically support the provinces in the organization of integrated micro-planning according to the village by village approach including in insecure, cross-border and emergency areas
- Provide technical and financial support to the implementation of the RED approach according to the specific needs of each province including insecure, cross-border and emergency areas.
- Financially and technically support the organization of AVI in 211 underperforming HZ (unvaccinated children ≥ 1500 children)
- Financially and technically support the organization of the Child Health Week which includes vitamin A supplementation and parasite treatment for recovery of unvaccinated or under vaccinated targets.
- Train 44 central level managers in MLM course (Program Management)
- At operational level support EVP (PHC) management training for 516 MCZ, 516 IS, 516 AC (Program Management)
- Provide technical and financial support to the provinces in the training of IT and ITA on EVP management and community based monitoring for 516 health zones (Program Management) with consideration for the specifics of unsafe, cross-border and emergency health zones
- For each coordination and branch (NC), organize integrated supervision every four months with a focus on problem health zones (e.g. technical, logistical, administration and finance, communication and surveillance)
- Drive the RO on the factors determining the use and delivery of vaccination services
- Provide RO on the factors related to the dropout rate between DTP 1 and DTP 3 in 11 health zones of the DRC
- Financially support the supervision three times a year of the health zones by coordinations and branches
- Financially support the supervision at least once per month from the health zones to the health centers

**DATA QUALITY IMPROVEMENT**

- Organize the data management tool revision workshop by incorporating the AEFV
- Lead assignments supporting DQS in the 44 branches
- Implement a DQS results sharing system from the Health Zones to the hierarchy (DQS results previously discussed during monthly data validation meetings and reports to the hierarchy)
- Lead 10 vaccination data quality evaluation assignments in the problem branches and Health Zones in 10 provinces
- Provide technical and financial support for data validation to the provinces and branches
- Provide technical and financial support to the provinces and branches for data validation in the health zones

- Provide technical support to conducting rapid coverage surveys (LQAS, cluster survey) once every half year with priority in the at risk, insecurity, cross-border and emergency zones
- Provide technical and financial support to organizing semiannual reviews in the 11 provinces (see management)
- Provide technical and financial support to organizing quarterly reviews in 44 branches (see management)
- Train 11 data managers, 44 MCA, 44 logistics experts for the EVP Branches, 11 provincial logistics experts in vaccination data management, laboratories and sentinel sites for the provinces and branches in data quality improvement
- Organize an independent vaccination coverage survey

**DELIVERY OF SERVICES: INTRODUCTION OF NEW VACCINES**

- Organize the new vaccines/PCV 13 post introduction evaluation in Katanga, Equateur and Province Orientale provinces
- Prepare the new vaccine introduction proposal (VPI)
- Document the AEFV in connection with the post marketing phase of new vaccine introduction
- **Implement the AEFV management system**

**LOGISTICS: Vaccine Supply and Quality**

- Purchase traditional vaccines and vaccination supplies
- Purchase new vaccines and vaccination supplies
- Supply the provinces and branches with quality vaccines and vaccination supplies with particular attention to the branches with insecure, cross-border and emergency Health Zones
- Create primary warehouses at the N'djili and Kisangani airports (advocacy mission for Kisangani)
- Acquire six 30 $m^3$ cold rooms for the branches (Mbujimayi, Goma, kin centre, Mbandaka, Aru and Tshikapa)
- Provide the health zones with 600 ice chests and 2000 vaccine carriers for vaccine supply
- Provide the health zones appropriate transportation means (vehicles, motorcycles and outboards) with particular attention to the branches with insecure, cross-border and emergency health zones
- Provide technical and financial support to CCL training in eight provinces (416 Health Zones)
- Provide financial support to reinvigorate the ANR
- Provide the provinces 500 40 L refrigerators for the Health Areas and 200 Refrigerators of over 100 L SDD Solar for the Health Zones
- Study of the solarization of cold rooms operating with an electrical generator as the main energy source
- Assure the maintenance of cold chain equipment by acquiring replacement parts
- establish projects for strengthening maintenance and repair of cold chain equipment in the Health Zones
- Provide three EVP coordinations (Lubumbashi, Kisangani and Mbuji-Mayi) with three refrigerated vehicles
- Support maintenance and repair of 1000 cold chain units by acquisition of replacement parts
- Organize Effective Vaccine Management Supervision based on the VMS tool
- Acquire 120 replacement part kits for the central level, PHD and branch generators
- Provide technical and financial support to DVD MT training in the provinces (to be combined with data

management training)

## SVA by Type

- Organize LVD rounds in February, April and July (integrated with the measles campaign) and in September
- Provide technical and financial support for promptly organizing responses around any new case of WPV and cVDPV
- Provide technical and financial support for organization of quality monitoring campaigns in seven provinces (integrated with VPO)
- Provide technical and financial support to prompt (72 hours) quality responses against measles epidemics in Health Zones
- Support training on better practices in seven provinces (Maniema, Katanga, Kasaï Occidental, Kasaï Oriental, Bandundu, Bas-Congo and Kinshasa)
- Provide technical and financial support to the organization of the second quality MNT passage and 63 targeted Health Zones and the third quality pass in 41 Health Zones in been doing, Katanga and Orientale province against MNT.

**DISEASE MONITORING**

- Reproduce and distribute the updated community based monitoring guide
- Reproduce the information collection tools for the community monitors
- Technically support the provincial level in the supervision, monitoring and evaluation of the implementation of the active search and priority Health Zone notification sites
- Provide reproduction and distribution of technical monitoring sheets (six sheets) in order to equip the notification sites of 6598 health areas in 350 health zones
- Organize the monitoring document review
- Organize two quick external reviews of the monitoring system in the priority provinces
- Organize a reflection workshop on environmental monitoring as a supplement to the AFP monitoring
- Organize cross-border meetings in the Bas Congo, Bandundu, Kasai Occidental, Katanga, Equateur and P. Orientale provinces with Angola and Congo Brazzaville on management of compatible cases
- Prepare technical files on the new community based monitoring guide
- Organize training supervision with focus on spreading in the branches and coordinations the tools for analyzing the risk of the occurrence of measles epidemics
- With IST Afro support organize a mixed workshop on yellow fever risk analysis and consideration of rubella in DRC
- Track operation of polio experts committees + office equipment
- With support of IST Afro organize a workshop on starting-up confinement-techniques subgroup activities
- Organize a national polio certification committee workshop for preparation of the 2013 annual report
- Hold one quarterly meeting for coordination on AEFV monitoring
- Organize training on AEFV for intermediate level participants from Maniema, Kasai Oriental, Bandundu and Sud Kivu (added)
- Implement a sentinel site monitoring system for monitoring HPV in collaboration with the NRHP
- Train site staff on HPV monitoring in collaboration with the NRHP

- Hold one quarterly meeting for coordination on HPV monitoring
- Train three physicians/nurses from 10 site hospitals on the detection, collection, preservation and transport of cervical biopsies in collaboration with the NRHP
- Provide 10 colposcopes, and collection and transport material to the sites
- Supervise sites once every half year
- Train ZMT and midwives in the city of Kinshasa on the monitoring of cervical cancer
- Provide the Health Zones with equipment for collecting blood for monitoring congenital rubella syndrome

## Communication

- Organize advocacy supporting vaccination with visits to parliament and provincial governments and assemblies in 10 provinces (Kinshasa, Bandundu, Kasaï Oriental, Kasaï Occidental, Equateur, Maniema, Katanga, Nord Kivu, Sud Kivu and Province Orientale)
- Organize an advocacy meeting with cellular telephone operators (Vodacom, Airtel, TIGO, Africell and Orange) in order to establish a partnership for promoting vaccination
- Organize four conferences-debates for raising awareness supporting vaccination in the higher education institutions and universities/faculties of medicine
- Organize the fourth African Vaccination Week in DRC
- Reproduce and distribute 10,320 image boxes, 9640 thank you cards and 10,340 vaccination schedule posters in 258 Health Zones
- Distribute radio-televised shows promoting vaccination through eight TV chains with national coverage (RTNC, Digital, RTGA, CCTV, Télé 50, B.One, Antenne A and Radio Okapi)
- Implement communication activities supporting polio, measles, yellow fever and MNT SVA (including mobilizers, community follow-up, work with resistant groups and special populations, local media, etc.)
- Train four central level managers, and 11 managers from the PHD provincial communication services in tracking and evaluation
- Provide technical support to intermediate level managers on training management teams for 229 Health Zones in communication for vaccination and essential family practices
- Train two central level EVP staff members on Advocacy and communication at Ouidah (IRSP)

### PROGRAM MANAGEMENT

- Organize 12 central level technical IACC meetings
- Organize 4 central level strategic IACC meetings
- Provide financial support for 12 technical IACC meetings once per month at the intermediate level
- Provide technical support once per quarter to the organization of technical IACC for the provinces
- Organize one national level midcourse review t the end of the first half of the year
- Organize one national level annual review at the end of the second half of the year
- Update the cMYP according to GVAP
- Organize the JRF preparation workshop
- Organize the GAVI status report preparation workshop

- Organize one internal audit assignment once per quarter from the Executive Management to the intermediate level (coordinations and branches)
- Once quarterly organize Administrative and Financial supervisory assignments in the 11 provinces and 22 branches with difficulties
- Once a year organize the monitoring assignment in the 65 Health Zones supported by GAVI HSS
- Organize two feedback sessions to the Parliament for the days for raising awareness of the provincial deputies on sustainable vaccination financing
- Provide tracking of the vote and passage of the law on vaccination in Parliament
- Quarterly grant performance bonus to central level EVP managers and workers
- Quarterly grant performance bonus to intermediate level EVP workers

### 5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety.

Please report what types of syringes are used and the funding sources of Injection Safety material in 2013.

| Vaccine | Types of syringe used in 2013 routine EVP | Funding sources of 2013 |
|---|---|---|
| BCG | SAB 0.05 ml | Government, Unicef, World Bank |
| Measles | SAB 0.5 ml | Government, UNICEF, Prosani |
| TT | SAB 0.5 ml | Government, UNICEF, Prosani |
| DTP-containing vaccine | SAB 0.5 ml | Government, UNICEF, Prosani, GAVI |
| YFV | SAB 0.5 ml | Government, GAVI |
| Receptacle | Receptacle (safety box), 5 L | Government, GAVI, UNICEF |
| PCV-13 | SAB 0.5 ml | Government, GAVI |

Does the country have an injection safety policy/plan? **Yes**

**If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?**

**If No:** When will the country develop an injection safety policy/plan? (Please report in the box below)

Yes, the implementation of this plan is partial and experienced problems following lack of financing

Please explain in 2013 how sharps waste is being disposed of, problems encountered, etc.

In 2013, wastes are still collected in safety boxes and are disposed of by burning and then burying in all health structures which vaccinate. However, some structures have improved furnaces and very few use incinerators

## 6. Vaccination Services Support (VSS)

### 6.1. Report on the use of VSS funds in 2013

Democratic Republic of the Congo (Kinshasa) is not submitting a report on the use of funds for vaccination services support (VSS) in 2013

### 6.2. Detailed expenditure of VSS funds during the calendar year

Democratic Republic of the Congo (Kinshasa) is not submitting a report on the use of funds for vaccination services support (VSS) in 2013

### 6.3. Request for VSS reward

Request for ISS reward achievement in 2013 is applicable for Democratic Republic of the Congo (Kinshasa)

## 7. New and Underused Vaccines Support (NVS)

### 7.1. Receipt of new & under-used vaccines for 2013 vaccination program

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Vaccination Program that GAVI communicated to you in its Decision Letter (DL)? Fill in the table below.

**Table 7. 1:** Vaccines received for 2013 vaccinations against approvals for 2013

| | [ A ] | [ B ] | | |
|---|---|---|---|---|
| **Vaccine Type** | **Total doses for 2013 in the Decision Letter** | **Total doses received by 31 December 2013** | **Total doses of postponed deliveries in 2013** | **Did the company record any stock shortages at any level during 2013?** |
| DTP-HepB-Hib | 9,508,000 | 11,561,450 | 778,500 | No |
| Pneumococcal (PCV 13) | 4,469,400 | 4,783,200 | 0 | Yes |
| Yellow Fever | 3,063,650 | 3,195,550 | 570,000 | Yes |

**Please also include any deliveries from the previous year received against this Decision Letter.*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilization than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock outageages? Overstocks? Problems with cold chain?, etc.) Doses discarded because VVM changed color or because of the expiry date?. etc.)

  In 2012, introduction of PCV 13, which had started in 2011, in four provinces (Bas Congo, Kinshasa, Nord and Sud Kivu) was interrupted in the other provinces because of lack of cofinancing. In September 2012 the introduction process resumed in the province of Bandundu and in 2013 in the remainder of the provinces. In the quantities of vaccines received in the country, there is the GAVI share and that of the government through cofinancing.

- What measures have you taken to improve vaccine management, for example, adjusting the plan for vaccine shipments? (in the country and with the UNICEF Procurement Division)

  **GAVI would also appreciate receiving comments from the countries on the feasibility of and interest in selecting and expediting multiple presentations of pentavalent vaccine ( single-dose and ten-dose vials) so as to minimize wastage and cost while maximizing coverage.**

  The distribution plan was adapted in keeping with the vaccine availability.

If **Yes** for any vaccination in **Table 7.1**, please describe the duration, reason and impact of stock outage, including if the stock outage was at the central, regional, district or at lower level.

Yes, we recorded four months of stock outage for yellow fever vaccine. This outage had affected the vaccination points; it was caused by the unavailability of yellow fever vaccine at the global level.

## 7.2. Introduction of a New Vaccine in 2013

7.2.1. If you were approved by GAVI to introduce a new vaccine in 2013, please refer to the vaccine introduction plan in the approved proposal and report on achievements:

| Yellow Fever, 5 dose(s) per vial, FREEZE-DRIED | | |
|---|---|---|
| **Phased introduction** | No | |
| **Nationwide introduction** | No | |
| **Was the time and scale of introduction as planned in the proposal? If No, Why?** | No | Yellow fever vaccine was introduced in the DRC in 2003. |

| Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | | |
|---|---|---|
| **Phased introduction** | Yes | 04/04/2011 |
| **Nationwide introduction** | No | |
| **Was the time and scale of introduction as planned in the proposal? If No, Why?** | No | Because there was no cofinancing of new vaccines (PCV 13) by the country, the process was temporarily interrupted in 2012. The measure was lifted after holding the external EVP review in 2012 and the progressive payment of the cofinancing for new vaccines. Thus, the introduction process continued in September 2012 in the Bandundu province October 2013 in the Equateur and Province Orientale provinces. |

| DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | | |
|---|---|---|
| **Phased introduction** | No | |
| **Nationwide introduction** | No | |
| **Was the time and scale of introduction as planned in the proposal? If No, Why?** | No | The DRC introduced pentavalent vaccine in 2009. |

7.2.2. For when is the Post Introduction Evaluation (PIE) planned? **March 2014**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document No. 9)

The postintroduction evaluation of PCV 13 started late March 2014 and the report is not yet available.

7.2.3. Adverse Event Following Vaccination (AEFV)

Is there a national dedicated vaccine pharmacovigilance capacity? **Yes**

Is there a national AEFV expert review committee? **Yes**

Does the country have an institutional development plan for vaccination safety? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Does your country have a risk communication strategy with preparedness plans to address potential vaccine crises? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhoea? **Yes**

b. paediatric bacterial meningitis or pneumococcal or meningococcal disease? **Yes**

Does your country conduct special studies around:

a. rotavirus diarrhoea? **No**

b. paediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

If so, does the National Vaccination Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the national sentinel surveillance systems and special studies data to provide recommendations on the data generated and how to further improve data quality? **Yes**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **Yes**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

The specific surveys for tracking the impact of the new pentavalent (DTP-HepB-Hib) and PCV 13 vaccines were not done. Nonetheless, monitoring laboratory results generated in the MBP-Rota sentinel sites indicates a reduction of confirmed cases of Hib: one case in 2009, three cases in 2010, zero cases in 2011, zero cases in 2012, and zero cases in 2013. In contrast for pneumococcus, two cases were reported in 2009 zero cases in 2010 one case in 2011, 14 cases in 2012 and four cases in 2013. The situation can be explained by the progressive introduction of PCV 13 in the country and the final provinces did not complete this introduction until late 2013. As for rota gastroenteritis, the available laboratory data show that 60% are due to rotavirus. It especially affects children under one year old. Additionally two cases of meningococcus were noted in 2010, 10 cases in 2012 and one case in 2013

## 7.3. New Vaccine Introduction Grant Lump Sums 2013

### 7.3.1. Financial Management Reporting

| | Amount US$ | Amount local currency |
|---|---|---|
| Funds received during 2013 (A) | 0 | 0 |
| Remaining funds (carry over) from 2012 | 0 | 0 |
| Total funds available in 2013 (C=A+B) | 0 | 0 |
| Total Expenditures in 2013 (D) | 0 | 0 |
| Carry over to 2014 (E=C-D) | 0 | 0 |

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 calendar year (Document Nos. 10, 11). (The instructions for this financial statement are available in **Annex 1**.). Financial statements should be signed by the Finance Manager of the EVP Program and the EVP Manager, or by the Permanent Secretary of Ministry of Health.

### 7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant.

The main activities which were undertaken in connection with the introduction of a new vaccine (PCV 13) were:

-supplying the provinces with vaccines and injection supplies

- reproducing and distributing revised EVP management tools and communication media

- reproducing training media

- doing the pre-introduction evaluation paired with advocacy in the provinces

- organize a meeting for updating the PCV 13 introduction and communication plan in the provinces, health districts and zones

- train the central, provincial, branch and health zone managers and also the health area service providers

- organize workshops to increase awareness of pediatricians and other clinicians at the central level and in the provinces

- organize post introduction supervision and training in the health centers which vaccinate

- organize post introduction evaluation of PCV 13

- organize awareness raising sessions for political-administrative authorities, media professionals, NGOs, religious groups, and community leaders on the new vaccine

- transmit TV and radio broadcasts on PCV 13

-organize the official introduction launch of PCV 13 at the national level and in the major cities of the provinces

Please describe any problems encountered in the implementation of the planned activities

Delay in disbursement of funds to the MST. The delay in the cofinancing payment which led to the suspension of the PCV 13 introduction process in 2012.

Please describe the activities that will be undertaken with any remaining balance of funds carried over to 2014

There was no balance.

## 7.4. Report on Country Co-financing in 2013

**Table 7.4:** Five questions on country co-financing

| | **Q.1: What were the actual co-financed amounts and doses in 2013?** | |
|---|---|---|
| **Co-Financed Payments** | **Total Amount in US$** | **Total Amount in Doses** |
| Selected vaccine #1: Yellow Fever, 5 dose(s) per vial, FREEZE-DRIED | 463,220 | 421,109 |
| Selected vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 112,000 | 560,000 |
| Selected vaccine #3: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | 78,940 | 394,700 |
| | | |
| | **Q.2: What were the cofinancing shares for the country from the following sources during the targeted year 2013?** | |
| Government | 2,727,193 | |
| Donor | 0 | |
| Other | 0 | |
| | | |
| | **Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?** | |
| **Co-Financed Payments** | **Total Amount in US$** | **Total Amount in Doses** |
| Selected vaccine #1: Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED | 0 | 0 |
| Selected vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | 0 | 0 |

| | | |
|---|---|---|
| Selected vaccine #3: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | 0 | 0 |
| | | |
| | **Q.4: When do you intend to transfer funds for co-financing in 2015 and what is the expected source of this funding** | |
| **Schedule of Co-Financing Payments** | Proposed Payment Date for 2015 | Funding source |
| Selected vaccine #1: Yellow Fever, 5 dose(s) per vial, FREEZE-DRIED | December | Government |
| Selected vaccine #2: Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID | December | Government |
| Selected vaccine #3: DTP-HepB-Hib, 1 dose(s) per vial, LIQUID | December | Government |
| | | |
| | **Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilizing funding for vaccination, including for co-financing.** | |
| | The country needed technical assistance in the domain of advocacy at the highest level of the country in order that:<br><br>1) the headings “Vaccine Purchasing and Cofinancing” become constraining expenditures for the Government and the State budget;<br><br>2) the disbursement of funds for purchasing vaccines and other supplies is done on time for avoiding stock outages at all levels;<br><br>3) the draft law on vaccination is voted in Parliament and authorized by the Head of State. | |

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Payment Default Policy: http://www.gavialliance.org/about/governance/program-policies/co-financing/

N/A

Is support from GAVI, in the form of new and under-used vaccines and injection supplies, reported on the national health sector budget? **No**

## 7.5. Vaccine management (EVSM/EVM/VMA)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. Information on the EVM tool can be found at http://www.who.int/vaccination_delivery/systems_policy/logistics/en/index6.html

*It is mandatory for the countries to conduct an EVM prior to an application for the introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timeliness. The progress report included in the implementation of this plan must be included in the annual report. The EVM assessment is valid for a period of three years.*

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **September 2011**

Please attach:

(a) EVM assessment **(Document No 12**)

(b) Improvement plan after EVM **(Document No 13**)

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14**)

Progress report on EVM/VMA/EVSM Improvement Plan’ is a mandatory requirement

Are there any changes to the Improvement Plan, with reasons provided? **No**

If yes, provide details.

Not applicable

When is the next Effective Vaccine Management (EVM) assessment planned? **September 2014**

## 7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

The Democratic Republic of the Congo (Kinshasa) is not presenting a report on the NVS in connection with a prevention campaign.

## 7.7. Change of vaccine presentation

Because of high demand during the first years of introduction and to guarantee the safety of introducing this new vaccine, the request from countries wishing to modify the presentation of the anti-pneumococcal vaccine (PCV 10 or PCV 13) will not be studied before 2015.

Countries wishing to switch from one anti-pneumococcal vaccine to another could request it in the 2014 annual progress report in order for it to be examined by the IRC.

If in 2013, for vaccines other than PCV you prefer to receive a vaccine presentation which is different from that which is currently provided to you (for example, number of doses per vial, form (liquid or freeze-dried), etc.), please give the properties of the vaccine and attach the minutes of the ICC meeting which recommended the change of the vaccine presentation. Please give the reasons for the vaccination form change request (for example, cost of administration, epidemiological data and number of children per session). The requests for vaccine form changes will be noted and considered according to the availability and the overall GAVI objective which is to shape the vaccine market, especially the existing contractual commitments. The country will be informed if it is possible to give a favorable response to the request, and in particular the supply availability schedule. If the vaccine is supplied by UNICEF, the planning for a change of presentation should start after receiving the decision letter for the following year. The country should be informed about the time required for undertaking the activities required for changing the presentation and also the availability of supplies.

You have requested one or more changes in presentation; here are the new presentations:

* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**

* **Vaccine Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED**

Please attach the minutes of the IACC and national consulting technical group on vaccination (CTGV; if applicable) meeting (Document **27**) which endorsed the requested change.

## 7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2014

Renewal of multiyear support for the Democratic Republic of the Congo (Kinshasa) is not available in 2014.

## 7.9. Request for continued support for vaccines for 2015 vaccination program

In order to request NVS support for 2015 vaccination, please do the following:

Confirm below that your request for 2015 vaccine support is compliant with table 7.11 Needs Calculation **Yes**

If you do not confirm, please explain

Not applicable

## 7.10. Weighted average prices of supply and related freight cost

**Table 7.10.1:** Commodities Cost

Estimated prices of supply are not disclosed

**Table 7.10.2:** Transportation costs

| Vaccine Antigens | Vaccine Types | No Threshold | $200,000 | | $250,000 | |
|---|---|---|---|---|---|---|
| | | | <= | > | <= | > |
| Yellow fever | YF | 7.80% | | | | |
| Meningococcal type A | HEPBHIB 23.80 % | 10.20% | | | | |
| Pneumococcal (PCV10) | HPV | 3.00% | | | | |
| Pneumococcal (PCV13) | HPV | 6.00% | | | | |
| Rotavirus | MEASLES | 5.00% | | | | |
| Measles, 2nd dose | MEASLES | 14.00% | | | | |
| DTP-HepB | MR | 2.00% | | | | |
| HPV bivalent | HPV2 | 3.50% | | | | |
| Rotavirus | HPV2 | 3.50% | | | | |
| MR | YF | 13.20% | | | | |

| Vaccine Antigens | Vaccine Types | $500,000 | | $2,000,000 | |
|---|---|---|---|---|---|
| | | <= | > | <= | > |
| Yellow fever | YF | | | | |
| Meningococcal type A | HEPBHIB 23.80 % | | | | |
| Pneumococcal (PCV10) | HPV | | | | |
| Pneumococcal (PCV13) | HPV | | | | |
| Rotavirus | MEASLES | | | | |
| Measles, 2nd dose | MEASLES | | | | |
| DTP-HepB | MR | | | | |
| DTP-HepB-Hib | MR | 25.50% | 6.40% | | |
| HPV bivalent | HPV2 | | | | |
| Rotavirus | HPV2 | | | | |
| MR | YF | | | | |

## 7.11. Calculation of requirements

**Table 7.11.1:** Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

| ID | | Source | | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|
| | **Number of surviving infants** | Table 4 | # | 3,017,220 | 3,107,737 | 3,200,969 | 9,325,926 |
| | **Number of children to be vaccinated with the first dose** | Table 4 | # | 2,382,899 | 2,921,273 | 3,040,920 | 8,345,092 |
| | **Number of children to be vaccinated with the third dose** | Table 4 | # | 2,382,899 | 2,921,273 | 2,880,872 | 8,185,044 |
| | **Vaccination coverage with the third dose** | Table 4 | % | 78.98% | 94.00% | 90.00% | |
| | **Number of doses per child** | Parameter | # | 3 | 3 | 3 | |
| | **Estimated vaccine wastage factor** | Table 4 | # | 1.33 | 1.05 | 1.11 | |
| | **Stock of vaccine on December 31, 2013 * (see explanatory note)** | | # | 4,203,900 | | | |
| | **Stock of vaccine on January 1, 2014 ** (see explanatory note)** | | # | 4,203,900 | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Number of doses per vial** | Parameter | # | | 10 | 10 | |
| | **AD syringes required** | Parameter | # | | Yes | Yes | |
| | **Reconstitution syringes required** | Parameter | # | | No | No | |
| | **Safety boxes required** | Parameter | # | | Yes | Yes | |
| **cc** | **Country co-financing per dose** | Co-financing table | $ | | 0.20 | 0.20 | |
| **ca** | **AD syringe price per unit** | Table 7.10.1 | $ | | 0.0450 | 0.0450 | |
| **cr** | **Reconstitution syringe price per unit** | Table 7.10.1 | $ | | 0 | 0 | |
| **cs** | **Safety box price per unit** | Table 7.10.1 | $ | | 0.0050 | 0.0050 | |
| **fv** | **Freight cost as % of vaccines' value** | Table 7.10.2 | % | | 6.40% | 6.40% | |
| **fd** | **Freight cost as % of devices' value** | Parameter | % | | 0.00% | 0.00% | |

* Vaccine stocks on December 31, 2012: the country is asked to report their total closing stock as of December 31st of the reporting year.

** Countries are additionally requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

**Not defined**

### Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

| | |
|---|---|
| **Co-financing group** | Low |

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| **Minimum co-financing** | 0.20 | 0.20 | 0.20 |
| **Recommended co-financing as per APR 2012** | | | 0.20 |
| **Your co-financing** | 0.20 | 0.20 | 0.20 |

**Table 7.11.2:** Estimated GAVI support and country co-financing (GAVI support)

| | | 2014 | 2015 |
|---|---|---|---|
| **Number of vaccine doses** | # | 8,850,300 | 8,950,700 |
| **Number of AD syringes** | # | 10,306,500 | 9,819,800 |
| **Number of reconstitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | 113,375 | 108,025 |
| **Total value to be co-financed by GAVI** | $ | 18,592,000 | 19,004,000 |

**Table 7.11.3:** Estimated GAVI support and country co-financing (Country support)

| | | 2014 | 2015 |
|---|---|---|---|
| **Number of vaccine doses** | # | 957,800 | 955,400 |

| | | | |
|---|---|---|---|
| **Number of AD syringes** | # | 0 | 0 |
| **Number of reconstitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | 0 | 0 |
| **Total value to be co-financed by country [1]** | $ | 1,962,000 | 1,981,500 |

**Table 7.11.4:** Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

| | | Formula | 2013 | 2014 | | |
|---|---|---|---|---|---|---|
| | | | | T | Government | GAVI |
| A | Country co-financing | *V* | 0,00 % | 9,76 % | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 2,382,899 | 2,921,273 | 285,253 | 2,636,020 |
| B1 | Number of children to be vaccinated with the third dose | *Table 4* | 2,382,899 | 2,921,273 | 285,253 | 2,636,020 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 3 | 3 | | |
| D | Number of doses needed | *B + B1 + Target for the 2nd dose ((B -0.41 x (B – B1))* | 7,148,697 | 8,763,819 | 855,759 | 7,908,060 |
| E | Estimated vaccine wastage factor | *Table 4* | 1,33 | 1,05 | | |
| F | Number of doses needed including wastage | *D X E* | | 9,202,010 | 898,547 | 8,303,463 |
| G | Vaccines buffer stock | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | | 605,671 | 59,142 | 546,529 |
| M | Stock to be deducted | *H1 – F of previous year x 0.375* | | | | |
| H1 | Calculated opening stock | *2014/(2014 – F)* | | | | |
| H2 | Stock on January 1 | *Table 7.11.1* | 0 | 4,203,900 | | |
| H3 | Shipment plan | *UNICEF shipment report* | | 9,202,500 | | |
| I | Total vaccine doses needed | *Round up((F + G – H) / vaccine package size) x vaccine package size* | | 9,808,000 | 957,719 | 8,850,281 |
| J | Number of doses per vial | *Vaccine parameter* | | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G – H) x 1.10* | | 10,306,439 | 0 | 10,306,439 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | | 113,371 | 0 | 113,371 |
| N | Cost of vaccines needed | *I x * vaccine price per dose (g)* | | 18,880,400 | 1,843,609 | 17,036,791 |
| Y | Cost of AD syringes needed | *K * AD syringe price per unit (ca)* | | 463,790 | 0 | 463,790 |
| P | Cost of reconstitution syringes needed | *L * reconstitution price per unit (cr)* | | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M * safety box price per unit (cs)* | | 567 | 0 | 567 |
| R | Freight cost for vaccines needed | *N * freight cost as of% of vaccines value (fv)* | | 1,208,346 | 117,992 | 1,090,354 |
| S | Freight cost for devices needed | *(O+P+Q) x * freight cost % of devices value (fd)* | | 0 | 0 | 0 |
| T | Total funding needed | *(N+O+P+Q+R+S)* | | 20,553,103 | 1,961,600 | 18,591,503 |
| U | Total country co-financing | *I * country co-financing per dose (cc)* | | 1,961,600 | | |
| V | Country co-financing % of GAVI supported proportion | *U / (N + R)* | | 9.76% | | |

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

**Table 7.11.4:** Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

| | | Formula | 2015 | | |
|---|---|---|---|---|---|
| | | | T | Government | GAVI |
| A | Country co-financing | *V* | 9.64% | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 3,040,920 | 293,280 | 2,747,640 |
| B1 | Number of children to be vaccinated with the third dose | *Table 4* | 2,880,872 | 277,844 | 2,603,028 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 3 | | |

| | | | | | |
|---|---|---|---|---|---|
| **D** | **Number of doses needed** | *B + B1 + Target for the 2nd dose ((B -0.41 x (B – B1))* | 8,897,093 | 858,074 | 8,039,019 |
| **E** | **Estimated vaccine wastage factor** | *Table 4* | 1.11 | | |
| **F** | **Number of doses needed including wastage** | *D X E* | 9,875,774 | 952,463 | 8,923,311 |
| **G** | **Vaccines buffer stock** | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | 252,662 | 24,368 | 228,294 |
| **M** | **Stock to be deducted** | *H1 – F of previous year x 0.375* | 222,721 | 21,481 | 201,240 |
| **H1** | **Calculated opening stock** | *2014/(2014 – F)* | 3,818,270 | 368,251 | 3,450,019 |
| **H2** | **Stock on January 1** | *Table 7.11.1* | | | |
| **H3** | **Shipment plan** | *UNICEF shipment report* | | | |
| **I** | **Total vaccine doses needed** | *Round up((F + G – H) / vaccine package size) x vaccine package size* | 9,906,000 | 955,378 | 8,950,622 |
| **J** | **Number of doses per vial** | *Vaccine parameter* | 10 | | |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) x 1.10* | 9,819,737 | 0 | 9,819,737 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.10* | 0 | 0 | 0 |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) / 100 x 1.10* | 108,018 | 0 | 108,018 |
| **N** | **Cost of vaccines needed** | *I x * vaccine price per dose (g)* | 19,306,794 | 1,862,031 | 17,444,763 |
| **Y** | **Cost of AD syringes needed** | *K * AD syringe price per unit (ca)* | 441,889 | 0 | 441,889 |
| **P** | **Cost of reconstitution syringes needed** | *L * reconstitution price per unit (cr)* | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | *M * safety box price per unit (cs)* | 541 | 0 | 541 |
| **R** | **Freight cost for vaccines needed** | *N * freight cost as of% of vaccines value (fv)* | 1,235,635 | 119,170 | 1,116,465 |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x * freight cost % of devices value (fd)* | 0 | 0 | 0 |
| **T** | **Total funding needed** | *(N+O+P+Q+R+S)* | 20,984,859 | 1,981,200 | 19,003,659 |
| **U** | **Total country co-financing** | *I * country co-financing per dose (cc)* | 1,981,200 | | |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* | 9.64% | | |

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

**Table 7.11.1:** Properties of pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

| ID | | Source | | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|
| | **Number of surviving infants** | Table 4 | # | 3,017,220 | 3,107,737 | 3,200,969 | 9,325,926 |
| | **Number of children to be vaccinated with the first dose** | Table 4 | # | 1,418,300 | 2,921,273 | 3,040,920 | 7,380,493 |
| | **Number of children to be vaccinated with the third dose** | Table 4 | # | 1,418,300 | 2,921,273 | 2,880,872 | 7,220,445 |
| | **Vaccination coverage with the third dose** | Table 4 | % | 47.01% | 94.00% | 90.00% | |
| | **Number of doses per child** | Parameter | # | 3 | 3 | 3 | |
| | **Estimated vaccine wastage factor** | Table 4 | # | 1.05 | 1.05 | 1.05 | |
| | **Stock of vaccine on December 31, 2013 * (see explanatory note)** | | # | 397,050 | | | |
| | **Stock of vaccine on January 1, 2014 ** (see explanatory note)** | | # | 397,050 | | | |
| | **Number of doses per vial** | Parameter | # | | 1 | 1 | |
| | **AD syringes required** | Parameter | # | | Yes | Yes | |
| | **Reconstitution syringes required** | Parameter | # | | No | No | |
| | **Safety boxes required** | Parameter | # | | Yes | Yes | |
| **cc** | **Country co-financing per dose** | Co-financing table | $ | | 0.20 | 0.20 | |
| **ca** | **AD syringe price per unit** | Table 7.10.1 | $ | | 0.0450 | 0.0450 | |
| **cr** | **Reconstitution syringe price per unit** | Table 7.10.1 | $ | | 0 | 0 | |
| **cs** | **Safety box price per unit** | Table 7.10.1 | $ | | 0.0050 | 0.0050 | |
| **fv** | **Freight cost as % of vaccines' value** | Table 7.10.2 | % | | 6.00% | 6.00% | |
| **fd** | **Freight cost as % of devices' value** | Parameter | % | | 0.00% | 0.00% | |

* Vaccine stocks on December 31, 2012: the country is asked to report their total closing stock as of December 31st of the reporting year.

** Countries are additionally requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

No variation observed.

## Co-financing tables for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

| | |
|---|---|
| **Co-financing group** | Low |

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| **Minimum co-financing** | 0.20 | 0.20 | 0.20 |
| **Recommended co-financing as per APR 2012** | | | 0.20 |
| **Your co-financing** | 0.20 | 0.20 | 0.20 |

**Table 7.11.2:** Estimated GAVI support and country co-financing (**GAVI support**)

| | | 2014 | 2015 |
|---|---|---|---|
| **Number of vaccine doses** | # | 9.434.200 | 9.131.700 |
| **Number of AD syringes** | # | 10.505.400 | 10.138.700 |
| **Number of reconstitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | 115.575 | 111.550 |
| **Total value to be co-financed by GAVI** | $ | 34.384.000 | 33.077.000 |

**Table 7.11.3:** Estimated GAVI support and country co-financing (**Country support**)

| | | 2014 | 2015 |
|---|---|---|---|
| **Number of vaccine doses** | # | 555.900 | 541.600 |
| **Number of AD syringes** | # | 0 | 0 |
| **Number of reconstitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | 0 | 0 |
| **Total value to be co-financed by country [1]** | $ | 1.998.000 | 1.935.000 |

**Table 7.11.4:** Calculation of needs for pneumococcal vaccine (PCV 13), one dose per vial, LIQUID (part 1)

| | | Formula | 2013 | 2014 | | |
|---|---|---|---|---|---|---|
| | | | | T | Government | GAVI |
| A | Country co-financing | *V* | 0.00% | 5.56% | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 1,418,300 | 2,921,273 | 162,544 | 2,758,729 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 3 | 3 | | |
| D | Number of doses needed | *B x C* | 4,254,900 | 8,763,819 | 487,630 | 8,276,189 |
| E | Estimated vaccine wastage factor | *Table 4* | 1.05 | 1.05 | | |
| F | Number of doses needed including wastage | *D X E* | | 9,202,010 | 512,011 | 8,689,999 |
| G | Vaccines buffer stock | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | | 1,183,592 | 65,857 | 1,117,735 |
| M | Stock to be deducted | *H2 of previous year – 0.25 x F of previous year* | | | | |
| H2 | Stock on January 1 | *Table 7.11.1* | 0 | | | |
| I | Total vaccine doses needed | *Round up((F + G – H) / vaccine package size) x vaccine package size* | | 9,990,000 | 555,856 | 9,434,144 |
| J | Number of doses per vial | *Vaccine parameter* | | 1 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G – H) x 1.10* | | 10,505,398 | 0 | 10,505,398 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | | 0 | 0 | 0 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | | 115,560 | 0 | 115,560 |
| N | Cost of vaccines needed | *I x * vaccine price per dose (g)* | | 33,876,090 | 1,884,906 | 31,991,184 |
| Y | Cost of AD syringes needed | *K * AD syringe price per unit (ca)* | | 472,743 | 0 | 472,743 |
| P | Cost of reconstitution syringes needed | *L * reconstitution price per unit (cr)* | | 0 | 0 | 0 |
| Q | Cost of safety boxes needed | *M * safety box price per unit (cs)* | | 578 | 0 | 578 |
| R | Freight cost for vaccines needed | *N * freight cost as of% of vaccines value (fv)* | | 2,032,566 | 113,095 | 1,919,471 |
| S | Freight cost for devices needed | *(O+P+Q) x * freight cost % of devices value (fd)* | | 0 | 0 | 0 |
| T | Total funding needed | *(N+O+P+Q+R+S)* | | 36,381,977 | 1,998,000 | 34,383,977 |
| U | Total country co-financing | *I * country co-financing per dose (cc)* | | 1,998,000 | | |
| V | Country co-financing % of GAVI supported proportion | *U / (N + R)* | | 5.56% | | |

**Table 7.11.4:** Calculation of needs for pneumococcal vaccine (PCV 13), one dose per vial, LIQUID (part 2)

| | | Formula | 2015 | | |
|---|---|---|---|---|---|
| | | | T | Government | GAVI |
| A | Country co-financing | *V* | 5.60% | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 3,040,920 | 170,255 | 2,870,665 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 3 | | |
| D | Number of doses needed | *B x C* | 9,122,760 | 510,765 | 8,611,995 |
| E | Estimated vaccine wastage factor | *Table 4* | 1.05 | | |
| F | Number of doses needed including wastage | *D X E* | 9,578,898 | 536,303 | 9,042,595 |
| G | Vaccines buffer stock | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | 94,223 | 5,276 | 88,947 |
| M | Stock to be deducted | *H2 of previous year – 0.25 x F of previous year* | 0 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| **H2** | **Stock on January 1** | *Table 7.11.1* | | | |
| **I** | **Total vaccine doses needed** | *Round up((F + G – H) / vaccine package size) x vaccine package size* | 9,673,200 | 541,583 | 9,131,617 |
| **J** | **Number of doses per vial** | *Vaccine parameter* | 1 | | |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) x 1.10* | 10,138,682 | 0 | 10,138,682 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.10* | 0 | 0 | 0 |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) / 100 x 1.10* | 111,526 | 0 | 111,526 |
| **N** | **Cost of vaccines needed** | *I x * vaccine price per dose (g)* | 32,598,684 | 1,825,133 | 30,773,551 |
| **Y** | **Cost of AD syringes needed** | *K * AD syringe price per unit (ca)* | 456,241 | 0 | 456,241 |
| **P** | **Cost of reconstitution syringes needed** | *L * reconstitution price per unit (cr)* | 0 | 0 | 0 |
| **Q** | **Cost of safety boxes needed** | *M * safety box price per unit (cs)* | 558 | 0 | 558 |
| **R** | **Freight cost for vaccines needed** | *N * freight cost as of% of vaccines value (fv)* | 1,955,922 | 109,508 | 1,846,414 |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x * freight cost % of devices value (fd)* | 0 | 0 | 0 |
| **T** | **Total funding needed** | *(N+O+P+Q+R+S)* | 35,011,405 | 1,934,640 | 33,076,765 |
| **U** | **Total country co-financing** | *I * country co-financing per dose (cc)* | 1,934,640 | | |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* | 5.60% | | |

**Table 7.11.1:** Specifications for Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED

| ID | | Source | | 2013 | 2014 | 2015 | TOTAL |
|---|---|---|---|---|---|---|---|
| | **Number of surviving infants** | Table 4 | # | 3,017,220 | 3,107,737 | 3,200,969 | 9,325,926 |
| | **Number of children to be vaccinated with the first dose** | Table 4 | # | 2,467,001 | 2,796,963 | 2,880,872 | 8,144,836 |
| | **Number of doses per child** | Parameter | # | 1 | 1 | 1 | |
| | **Estimated vaccine wastage factor** | Table 4 | # | 1.22 | 1.67 | 1.18 | |
| | **Stock of vaccine on December 31, 2013 * (see explanatory note)** | | # | 495,500 | | | |
| | **Stock of vaccine on January 1, 2014 ** (see explanatory note)** | | # | 495,500 | | | |
| | **Number of doses per vial** | Parameter | # | | 10 | 10 | |
| | **AD syringes required** | Parameter | # | | Yes | Yes | |
| | **Reconstitution syringes required** | Parameter | # | | Yes | Yes | |
| | **Safety boxes required** | Parameter | # | | Yes | Yes | |
| **cc** | **Country co-financing per dose** | Co-financing table | $ | | 0.20 | 0.20 | |
| **ca** | **AD syringe price per unit** | Table 7.10.1 | $ | | 0.0450 | 0.0450 | |
| **cr** | **Reconstitution syringe price per unit** | Table 7.10.1 | $ | | 0 | 0 | |
| **cs** | **Safety box price per unit** | Table 7.10.1 | $ | | 0.0050 | 0.0050 | |
| **fv** | **Freight cost as % of vaccines' value** | Table 7.10.2 | % | | 7.80% | 7.80% | |
| **fd** | **Freight cost as % of devices' value** | Parameter | % | | 10.00% | 10.00% | |

* Vaccine stocks on December 31, 2012: the country is asked to report their total closing stock as of December 31st of the reporting year.

** Countries are additionally requested to provide their opening stock for 1st January 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

## Co-financing tables for Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED

| | |
|---|---|
| **Co-financing group** | Low |

| | 2013 | 2014 | 2015 |
|---|---|---|---|
| **Minimum co-financing** | 0.20 | 0.20 | 0.20 |
| **Recommended co-financing as per APR 2012** | | | 0.20 |
| **Your co-financing** | 0.20 | 0.20 | 0.20 |

**Table 7.11.2:** Estimated GAVI support and country co-financing (**GAVI support**)

| | | 2014 | 2015 |
|---|---|---|---|
| **Number of vaccine doses** | # | 3 812 300 | 2 801 400 |
| **Number of AD syringes** | # | 2 988 500 | 3 192 100 |
| **Number of reconstitution syringes** | # | 505 000 | 376 300 |
| **Number of safety boxes** | # | 38 450 | 39 275 |
| **Total value to be co-financed by GAVI** | $ | 4 646 500 | 3 255 500 |

**Table 7.11.3:** Estimated GAVI support and country co-financing (**Country support**)

| 2014 | 2015 |
|---|---|

| | | | |
|---|---|---|---|
| **Number of vaccine doses** | # | 778 600 | 619 200 |
| **Number of AD syringes** | # | 0 | 0 |
| **Number of reconstitution syringes** | # | 0 | 0 |
| **Number of safety boxes** | # | 0 | 0 |
| **Total value to be co-financed by country [1]** | $ | 918 500 | 684 500 |

**Table 7.11.4:** Calculation of requirements for Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED (part 1)

| | | Formula | 2013 | 2014 | | |
|---|---|---|---|---|---|---|
| | | | | T | Government | GAVI |
| A | Country co-financing | *V* | 0.00% | 16.96% | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 2,467,001 | 2,796,963 | 474,330 | 2,322,633 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | 1 | | |
| D | Number of doses needed | *B x C* | 2,467,001 | 2,796,963 | 474,330 | 2,322,633 |
| E | Estimated vaccine wastage factor | *Table 4* | 1.22 | 1.67 | | |
| F | Number of doses needed including wastage | *D X E* | | 4,670,929 | 792,132 | 3,878,797 |
| G | Vaccines buffer stock | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | | 415,297 | 70,430 | 344,867 |
| M | Stock to be deducted | *H2 of previous year – 0.25 x F of previous year* | | | | |
| H2 | Stock on January 1 | *Table 7.11.1* | 0 | | | |
| I | Total vaccine doses needed | *Round up((F + G – H) / vaccine package size) x vaccine package size* | | 4,590,800 | 778,543 | 3,812,257 |
| J | Number of doses per vial | *Vaccine parameter* | | 10 | | |
| K | Number of AD syringes (+ 10% wastage) needed | *(D + G – H) x 1.10* | | 2,988,437 | 0 | 2,988,437 |
| L | Reconstitution syringes (+ 10% wastage) needed | *(I / J) x 1.10* | | 504,989 | 0 | 504,989 |
| M | Total of safety boxes (+ 10% of extra need) needed | *(K + L) / 100 x 1.10* | | 38,428 | 0 | 38,428 |
| N | Cost of vaccines needed | *I x * vaccine price per dose (g)* | | 5,022,336 | 851,726 | 4,170,610 |
| Y | Cost of AD syringes needed | *K * AD syringe price per unit (ca)* | | 134,480 | 0 | 134,480 |
| P | Cost of reconstitution syringes needed | *L * reconstitution price per unit (cr)* | | 2,020 | 0 | 2,020 |
| Q | Cost of safety boxes needed | *M * safety box price per unit (cs)* | | 193 | 0 | 193 |
| R | Freight cost for vaccines needed | *N * freight cost as of% of vaccines value (fv)* | | 391,743 | 66,435 | 325,308 |
| S | Freight cost for devices needed | *(O+P+Q) x * freight cost % of devices value (fd)* | | 13,670 | 0 | 13,670 |
| T | Total funding needed | *(N+O+P+Q+R+S)* | | 5,564,442 | 918,160 | 4,646,282 |
| U | Total country co-financing | *I * country co-financing per dose (cc)* | | 918,160 | | |
| V | Country co-financing % of GAVI supported proportion | *U / (N + R)* | | 16.96% | | |

**Table 7.11.4:** Calculation of requirements for Yellow Fever, 10 dose(s) per vial, FREEZE-DRIED (part 2)

| | | Formula | 2015 | | |
|---|---|---|---|---|---|
| | | | T | Government | GAVI |
| A | Country co-financing | *V* | 18.10% | | |
| B | Number of children to be vaccinated with the first dose | *Table 4* | 2,880,872 | 521,449 | 2,359,423 |
| C | Number of doses per child | *Vaccine parameter (schedule)* | 1 | | |
| D | Number of doses needed | *B x C* | 2,880,872 | 521,449 | 2,359,423 |
| E | Estimated vaccine wastage factor | *Table 4* | 1.18 | | |
| F | Number of doses needed including wastage | *D X E* | 3,399,429 | 615,309 | 2,784,120 |
| G | Vaccines buffer stock | *((D – D of previous year) x 0.375) + (((D x E – D) – (D of previous year x E of previous year – D of previous year)) x 0.375)* | 20,978 | 3,798 | 17,180 |
| M | Stock to be deducted | *H2 of previous year – 0.25 x F of previous year* | 0 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| **H2** | **Stock on January 1** | *Table 7.11.1* | | | |
| **I** | **Total vaccine doses needed** | *Round up((F + G – H) / vaccine package size) x vaccine package size* | 3,420,500 | 619,123 | 2,801,377 |
| **J** | **Number of doses per vial** | *Vaccine parameter* | 10 | | |
| **K** | **Number of AD syringes (+ 10% wastage) needed** | *(D + G – H) x 1.10* | 3,192,036 | 0 | 3,192,036 |
| **L** | **Reconstitution syringes (+ 10% wastage) needed** | *(I / J) x 1.10* | 376,256 | 0 | 376,256 |
| **M** | **Total of safety boxes (+ 10% of extra need) needed** | *(K + L) / 100 x 1.10* | 39,252 | 0 | 39,252 |
| **N** | **Cost of vaccines needed** | *I x * vaccine price per dose (g)* | 3,506,013 | 634,601 | 2,871,412 |
| **Y** | **Cost of AD syringes needed** | *K * AD syringe price per unit (ca)* | 143,642 | 0 | 143,642 |
| **P** | **Cost of reconstitution syringes needed** | *L * reconstitution price per unit (cr)* | 1,506 | 0 | 1,506 |
| **Q** | **Cost of safety boxes needed** | *M * safety box price per unit (cs)* | 197 | 0 | 197 |
| **R** | **Freight cost for vaccines needed** | *N * freight cost as of% of vaccines value (fv)* | 273,470 | 49,500 | 223,970 |
| **S** | **Freight cost for devices needed** | *(O+P+Q) x * freight cost % of devices value (fd)* | 14,535 | 0 | 14,535 |
| **T** | **Total funding needed** | *(N+O+P+Q+R+S)* | 3,939,363 | 684,100 | 3,255,263 |
| **U** | **Total country co-financing** | *I * country co-financing per dose (cc)* | 684,100 | | |
| **V** | **Country co-financing % of GAVI supported proportion** | *U / (N + R)* | 18.10% | | |

## 8. Injection Safety Support (ISS)

This type of support is not available.

## 9. Health System Strengthening Support (HSS)

**Instructions for reporting on HSS funds received**

1. Please complete this section **only if your country was approved for and received HSS funds before or during January to December 2013**. All countries are expected to report on:
   a. Progress achieved in 2013
   b. HSS implementation during January – April 2014 (interim reporting)
   c. Plans for 2015
   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited

implementation in 2013, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **May 15, 2014**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2014, the HSS reports are expected by GAVI Alliance by September 2014.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately. Please use additional space than that provided in this reporting template, as necessary.

4. If you wish to modify the previously approved objectives, activities and budget (reprogramming), please request the reprogramming guidelines from the person responsible for your country at the GAVI Secretariat or send an email addressed to: gavihss@gavialliance.org.

5. If you are requesting a new block of funding, please so indicate in Section 9.1.2.

6. Please make sure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. 7. Please attach all required supporting documents. These documents include:

a. Minutes of all the HSCC meetings held in 2013

b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

c. The latest Health Sector Review Report

d. Financial statement for the use of HSS funds in the 2013 calendar year

e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year.

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

## 9.1. Report on the use of HSS funds in 2013 and request of a new block

For the countries which have already received final payment of the GAVI financing approved in connection with HSS support and who are requesting no other financing: Is the implementation of the HSS subsidy completed? **Yes**

If NO, please indicate the anticipated date for completion of the implementation of the HSS grant.

Please attach all the studies and evaluations concerning the GAVI HSS grant or financed by it.

Whenever they exist, please attach data disaggregated by gender, rural/urban areas, and by district/country, specifically for vaccination coverage indicators. This is particularly important if the GAVI HSS grants serve

specific populations and/or geographic zones in the country.

If CSO were involved in the implementation of the HSS grant, please attach a list of those involved in the implementation of the grant, the financing received by the CSO from the GAVI HSS grant and the activities that they performed. If CSO involvement was already called for in the initial GAVI approved proposal, but no financing was provided to the CSO, please explain why.

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

Please specify all sources for all data used in this report.

Please attach the latest report of national results/monitoring and evaluation framework for the health sector (with real data reported for the most recent year available in the country).

9.1.1. Report on the use of HSS funds in **2013**

Please complete Table 9.1.3.a and 9.1.3.b (as per APR) for each year of your country's approved multi-year HSS program and both in US$ and local currency

**Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.**

9.1.2. Please indicate if you are requesting a new block of funding **No**

If yes, please indicate the amount of funding requested: US$

These funds should be sufficient to assure implementation of the allocation under HSS until December 2015.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| Original annual budgets (per the originally approved HSS proposal) | 37242750 | 110909538 | 7660518 | | | |
| Revised annual budgets (if revised by previous Annual Progress Reviews) | 21525562 | 20139390 | 15149548 | | | |
| Total funds received from GAVI during the calendar year (A) | 41665000 | | | | | 15151000 |
| Remaining funds (carry over) from previous year (B) | 0 | 41556480 | 35715187 | 17248126 | 16896284 | 10109536 |
| Total Funds available during the calendar year (C=A+B) | 41665000 | 41556480 | 35715187 | 17248126 | 16896284 | 25260536 |
| Total expenditure during the calendar year (D) | 108520 | 5841293 | 18469961 | 381842 | 6786748 | 5698705 |
| Balance carried forward to next calendar year (E=C-D) | 41556480 | 35715187 | 17248126 | 16896284 | 10109536 | 19561830 |
| **Amount of funding requested for future** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **calendar year(s) [please ensure you complete this row if you are requesting a new tranche]** | | | | | | |

| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Original annual budgets (per the originally approved HSS proposal) | | | | |
| Revised annual budgets (if revised by previous Annual Progress Reviews) | | | | |
| Total funds received from GAVI during the calendar year (A) | | | | |
| Remaining funds (carry over) from previous year (B) | 19561830 | | | |
| Total Funds available during the calendar year (C=A+B) | 19561830 | | | |
| Total expenditure during the calendar year (D) | | | | |
| Balance carried forward to next calendar year (E=C-D) | | | | |
| **Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]** | 0 | | | |

Table 9.1.3b (Local currency)

| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| Original annual budgets (per the originally approved HSS proposal) | | | | | | |
| Revised annual budgets (if revised by previous Annual Progress Reviews) | | | | | | |
| Total funds received from GAVI during the calendar year (A) | | | | | | |
| Remaining funds (carry over) from previous year (B) | | | | | | |
| Total Funds available during the calendar year (C=A+B) | | | | | | |
| Total expenditure during the calendar year (D) | | | | | | |
| Balance carried forward to next calendar year | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| (E=C-D) | | | | | | |
| **Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]** | | | | | | |

| | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Original annual budgets (per the originally approved HSS proposal) | | | | |
| Revised annual budgets (if revised by previous Annual Progress Reviews) | | | | |
| Total funds received from GAVI during the calendar year (A) | | | | |
| Remaining funds (carry over) from previous year (B) | | | | |
| Total Funds available during the calendar year (C=A+B) | | | | |
| Total expenditure during the calendar year (D) | | | | |
| Balance carried forward to next calendar year (E=C-D) | | | | |
| **Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]** | 0 | | | |

**Report of Exchange Rate Fluctuation**

Please indicate in Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

| Exchange Rate | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| Opening on 1 January | 523.28 | 680.77 | 909.89 | 920.15 | 917.79 | 915.95 |
| Closing on 31 December | 606.8 | 904.53 | 911.78 | 911.73 | 914.92 | 926.63 |

**Detailed expenditure of HSS funds during the 2013 calendar year**

Please attach a detailed financial statement for the use of HSS funds during the 2013 calendar year (Terms of reference for this financial statement are attached in the online APR Annexes). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January-April 2014 period are reported in Table 14, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

**Financial management of HSS funds**

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for program use.

Please include details on: the type of bank account(s) used (business or government account); budget approval process; way funds are directed to sub-national levels; provisions for preparing national and sub-national level financial reports; and the global role of ICC in the process.

In May 2011 the Government to the DRC and GAVI Alliance signed an Aide-Memoire on recommendations from the 2009 financial evaluations which defines the GAVI funds management methods by replacing the memorandum of understanding signed in 2008 between the Ministry of Public Health and its partners (WHO, UNICEF, World Bank and health inter-lender group) for managing these funds. This Aide-Memoire complies with all GAVI Guidelines approved by its Board of Directors and sent to various eligible countries including the DRC specifically as it relates to planning, budgeting, disbursement and coordination described below: The annual and half-yearly disbursement plans are prepared by the project manager and consolidated by the experts from the Consulting and Planning Division and the selected financial management agency. The plan thus consolidated is sent for approval to the National Steering Committee through the GAVI HSS Ad Hoc Committee which is its origin.

The minutes from the Ad Hoc Committee meeting together with the approved plan are the items which trigger the disbursement process. However, it should be submitted to GAVI Alliance in advance per the instructions from the Aide-Memoire to get the disbursement authorization. Once authorization is granted, the disbursement plan is filed with the Management Support Team (MST) for scheduling said disbursement and the associated funds are paid from the main account (housed in a business bank “BIAC”), for which the National Minister of Public Health and the WHO Representative are the signers, into the secondary account (business, in the same bank BIAC) managed by the Central AGEFIN (KPMG).

The General Secretary for Health informs all the beneficiaries by official letter of the amount required for implementation of the activity/activities according to their respective operational action plans.

Thus, the funds will be disbursed by KPMG and its network of provincial financial management agencies (which at this time includes 19 offices) for the benefit of the users on the basis of a payment order issued by the MST or the provincial Inspector Physician. Once the activity is done, the supporting documents are gathered by KPMG through its provincial network of financial management agencies.

KPMG then prepares the quarterly financial report and sends it to the MST; once the report is approved by the Ad Hoc Commission it will be sent to the General Secretary for Health who will send it to GAVI for endorsement.

**Has an external audit been conducted? Yes**

**External audit reports for HSS programs are due to the GAVI Secretariat six months following the close of your government’s fiscal year. If an external audit report is available for your HSS program during your government’s most recent fiscal year, this must also be attached (Document Number: 21)**

## 9.2. Progress on HSS activities in the 2013 fiscal year

Please report on major activities conducted to strengthen vaccination using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and decision letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2013 reporting year

| Major Activities (insert as many rows as necessary) | Planned Activity for 2013 | Percentage of Activity completed (annual) (where applicable) | Source of information/data (if relevant) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Activity 1.1** | Support operation of National Steering Committee | 49 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.3** | Status report in the target provinces | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.8** | Preparation of the human resources development plan for health | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.9** | Prepare the central level standards | 0 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.10** | Support the central level assignments for accompanying preparation of Operation Action Plans in the Provinces | 99 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.12** | Monitor implementation of the action plans for the supported provinces | 35 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.14** | Participate in WHO in Geneva World Assembly type colloquia | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.15** | Organize monthly NSC meetings | 50 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.17** | Organize the major meeting of the National Steering Committee presided by the National Minister of Public Health | 93 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.18** | Provide for operation of the HR and Health System observatory established in the sector | 97 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.22** | Provide for the operation of the internet connection placed at the health system central level | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.26** | Support organization of TCC-HS meetings every quarter | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.27** | Support organization of the national sector review | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.28** | Short-term technical assistance and internal audit | 42 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.33** | Training on contractualization awarding procurement contracts | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.35** | International planning course to support this training for MPH managers | 100 | 2013 Central AGEFIN & MST technical and financial report |
| **Activity 1.36** | Support central level EVP operation | 89 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual EVP |
| **Activity 2.1** | Support preparation of operational action plans for three target PHD | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.2** | Supervision of Health Zones by Health District teams (4 times per year) | 59 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.3** | Supervision of target Health Zones by three target PHD (4 times per year | 49 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.6** | Rehabilitate the offices of three target PHD (Kinshasa,, Bas Congo and Sud Kivu) | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.8** | Purchase three photocopier kits for three target PHD | 94 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |

| | | | |
|---|---|---|---|
| **Activity 2.9** | Purchase 15 portable computers for the three target PHD | 95 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.10** | Provide for the operation of the internet connection established in the province | 69 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.17** | Support planning in the provinces by Central Level experts | 42 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.19** | Support operation of three target PHD (Kinshasa, Bas Congo and Sud Kivu) | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.20** | Support organization of monthly meetings of the Provincial Steering Committee Commissions | 54 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.21** | Support bimonthly meetings of the technical secretariat in the target provinces | 98 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.24** | Support organization of the annual PSC meeting and monitoring of performance in 65 Health Zones | 42 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.25** | Support operation of 20 target health districts | 98 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.26** | Support operation of 44 EVP branches | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 2.27** | Support operation of 11 EVP provincial coordinations | 46 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.1** | Support preparation of operational action plans for 65 target Health Zones | 98 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.2** | Rehabilitate/construct health centers | 0 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.8** | Support the operation of 65 GRH and 65 Health Zone offices | 72 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.13** | Provide health centers with bicycles for vaccination | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.15** | Supervise Health Centers by Health Zone management teams | 62 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.18** | Support Health Zone vaccination activities (RED approach) | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 3.19** | Support raising the population's awareness of vaccination by members of civil society organizations | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual for provinces and CSO |
| **Activity 3.20** | Support strengthening the skills of community members through CSO in raising awareness supporting routine EVP and catching up with children not reached by vaccination | 72 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual for provinces and CSO |
| **Activity 4.3** | Train/update registered nurses of Health Centers on PHC in their respective hospitals | 90 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 4.4** | Train four Head of Health Zone physicians in healthcare | 100 | 2013 Central AGEFIN & MST technical and financial report& |

| | | | |
|---|---|---|---|
| | economics | | 2013 Annual Provincial |
| **Activity 4.10** | Pay service provider bonuses in the HZ, HD, PHD and central level | 100 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 5.1** | National technical assistance for expertise not found in the sector | 37 | 2013 Central AGEFIN & MST technical and financial report& 2013 Annual Provincial |
| **Activity 5.2** | Support organization of the external audit for the 2012 operating period | 100 | 2013 Central AGEFIN & MST technical and financial report |

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

| Major Activities (insert as many rows as necessary) | Explain progress achieved and relevant constraints |
|---|---|
| **Support central level steering of the Health System** | 16/17 activities were completed with a 79.4% average completion rate<br>Obstacles encountered: (i) sometimes funds were made available late by AGEFIN <KPMG> to central divisions and programs; (ii) difficulties correctly preparing the quality queries for central level beneficiaries; (iii) missing and insufficient communication between both parties and sometimes needs unstated by the beneficiaries, in the end long process for awarding procurements discourages beneficiaries from expressing their need. |
| **Support provincial steering of the Health System** | 15/15 activities were completed with a 76.4% average completion rate<br>Obstacles encountered: (i) funds made available late from central AGEFIN to provincial AGEFIN <FDSS and others> and provincial AGEFIN to the Provincial Health Divisions, Coordination and Branches and EVP Health Zones; (ii) difficulties correctly preparing the quality queries for provincial level and health zone beneficiaries; (iii) missing and insufficient communication between the two parties; (iv) finally long process for awarding procurement contracts taking 3 to 6 months for acquisitions, rehabilitation and various purchases. |
| **Provide for the development of 65 Health Zones According to the HSSS** | 7/8 activities were completed with a 64.6% average completion rate<br>Obstacles encountered: (i) funds made available late by provincial AGEFIN <FDSS and others> to central offices and health centers; (ii) difficulties correctly preparing the quality requests by the beneficiary Health Centers and Health Zones' central offices; (iii) missing and insufficient communication between Health Zones and Provincial AGEFIN, finally enormous distance between provincial AGEFIN and Health Zones ranging from 50 to 500 km; long process for awarding procurement contracts taking 3 to 6 months for acquisition, rehabilitation and various purchases supporting Health Zones especially resupply of vaccines, medicines, fuel, lubricant and vehicle maintenance |
| **Support Health System HR development** | 3/3 activities were completed with a 95% average completion rate<br>Obstacles encountered: The DRC is a vast country for timely evaluation of all the quarterly performance bonus recipients and missing and insufficient communication between the beneficiaries and AGEFIN |

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Two major activities out of 45 planned have not been done. It involves preparation of standards for central level reorganization according to new organic framework. In fact, a new organic standards-based framework was advanced by the upper levels and new standards had to be developed suited to this new framework, given the emergencies which were in the sector based on this new organic framework, the Consulting and Planning Division responsible for steering this activity had not had the material time to do it and the activity was postponed to 2014. The second activity not done was the rehabilitation or construction of health centers.

This activity was not done in 2012 or in 2013 because at the sector level we would like to raise the option whether it is necessary to rehabilitate or build the Health Centers according to a standard plan accepted by all. To date, a standard construction plan has been accepted by all and the option raised is the construction of Health Centers with sustainable materials and whose average total cost would be $100,000 per Health Center; the no objection opinion is expected from GAVI Alliance for kicking off the 2014 construction.

The other activities not 100% completed were that way for these reasons among others: **the funds were sometimes made available late by AGEFIN to the beneficiaries both nationally and provincially; difficulties correctly preparing the quality requests by the Health Centers, Health Zones, Provincial Health Division and other central level beneficiaries; missing or insufficient communication between Health Zones, Provincial Health Divisions and Provincial AGEFIN; finally long process for awarding procurement contracts taking 3 to 6 months for acquisitions, PHD rehabilitations, various purchases for Health Zones, branches, EVP Coordination, PHD, Health Directions and Programs, especially the resupply of vaccines, medicines, fuel, lubricant and vehicle maintenance**

9.2.3 If GAVI HSS grant has been utilized to provide national health personnel incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

Yes, the additional bonuses given to health sector human resources at all levels of our healthcare pyramid have served to significantly improve the geographic coverage with health staff especially in rural areas, improve the service quality and stabilize human resources nationally. With these funds it was additionally possible to prepare the national human resource development plan and the human resources observatory for health at the sector level in synergy with funds from other partners in particular Japanese cooperation and the WHO.

## 9.3. General overview of targets achieved

Please complete Table 9.3 for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2012 from your original HSS proposal.

**Table 9.3:** Progress on targets achieved

| Name of Objective or Indicator (Insert as many rows as necessary) | Reference | | Agreed target till end of support in original HSS application | 2013 Target | | | | | | Data Source | Explanation if any targets were not achieved |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline value | Baseline source/date | | | 2009 | 2010 | 2011 | 2012 | 2013 | | |
| **Proportion of provinces with operating PSC** | 0% | 2005 DEP (annual report) | 100% | 100% | 0% | 54% | 81% | 100% | 100% | 2013 provincial annual report | |
| **Healthcare coverage in the 65 health zones** | 20% | 2005 DEP (annual report) | 80% | 80% | 20% | 50% | 75% | 85% | 88% | 2013 provincial annual report | |
| **% additional DTP3 vaccinated children in 65 health zones** | 0% | 2006 EVP (annual report) | 20% | 20% | 11.9% | 0% | 0% | 15% | 20% | 2013 CSO and provincial annual report | |
| **% additional measles vaccinated children in 65 health zones** | 0% | 2006 EVP (annual report) | 20% | 20% | 12% | 0% | 0% | 10% | 20% | 2013 CSO and provincial annual report | |
| **Measles vaccination coverage in 515 Health Zones in the DRC** | 77% | 2006 EVP Report | 90% | 90% | 84.1% | 87% | 84.9% | 89% | 88% | 2013 EVP Annual Report | Vaccine outages in the health zones worse in the provinces of the DRC with armed conflict, instability of service providers and insufficient implementation |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | of the RED approach |
| **DTP3 vaccination coverage in 515 Health Zones in the DRC** | 77.2% | 2006 EVP Report | 90% | 90% | 88.5% | 77.8% | 89.7% | 90.9% | 90% | 2013 EVP Annual Report | |
| **Mortality rate for children under 5/1000 live births** | 203 | MICS2 survey in 2001 | 185 | < 185 | 185 | 185 | 148 | 148 | 148 | 2007 DRC HDS survey report | |
| **Number of provinces with functional basket funding** | 0 | 2005 DEP annual sector report | 11 | 11 | 0 | 6 | 7 | 7 | 7 | Provinces' annual report | processes not yet finalized in the other provinces |
| **Existence of a single steering committee** | 0 | 2005 DEP annual report | 1 | 1 | 1 | 1 | 1 | 1 | 1 | December 3, 2009 decision creating NSC and PSC | |
| **Allocated budget execution rate and 65 Health Zones** | 40% | 2005 DEP annual sector report | 80% | 80% | 14% | 63.3% | 4% | 32% | 83% | 2013 Central AGEFIN & MST technical and financial report | |
| **Proportion of functional health zones among the targets** | 0% | 2005 DEP annual sector report | 100% | 100% | 45% | 75% | 100% | 100% | 100% | Provinces' annual report | |

## 9.4. Program Implementation in 2013

9.4.1. Please describe the main achievements of 2013, especially the dropping of the health service programs, and indicate how the funds allocated under HSS contributed to vaccination program strengthening.

The main achievements of 2013, especially the dropping of the health service programs and strengthening of the DRC vaccination program:

1. Continuing the implementation of the financial sector reform and putting the Management Support Team and central AGEFIN into operation and also the extension of the AGEFIN provincial fiduciary network to 29 coordinations and branches throughout this vast country.

2. Strengthening of the health system by a new organic framework which comprises 26 Provincial Health Divisions instead of 11

3. Launching the recruiting process for seven PHD managers by calling for candidacies and rationalizing the PHD human resources structured into four principal professions: Technical support accompanying the Health Zones, professional resource manager, health information system, hygiene and inspection and control

4. Strengthening the vaccine storage capacity at the central level, and in 11 coordinations and 44 branches by providing them a refrigerated truck for vaccine transportation and 60 solar refrigerators.

5. Train intermediate level EVP managers (Province) in MLM (EVP program management)

6. Improve healthcare coverage in terms of continuing to equip 85 health centers and 17 general referral hospitals

7. Strengthen the National Medication Supply System by continuing to open lines of credit for purchasing medicines for the 65 Health Zones under GAVI-HSS support.

8. Continue implementation of the NHDP by preparation at every level of the system (central, intermediate and Health Zones) of operational action plans under the supervision of central level experts.

9. Revisit the 2012-2015 EVP cMYP

10. Preparation the strategy for accelerating achievement of Millennium Development Goals 3 and 4

11. Strengthen epidemiological monitoring at every health system level with zero cases of wild poliovirus declared in DRC.

12. Organize measles vaccination campaign in four provinces (Equateur, Province Orientale and Sud and Nord Kivu)

13. Introduce PCV 13 in the remaining six provinces of the country in particular in: Kasaï Occidental, Kasaï Oriental, Maniema, Katanga, Equateur and Province Orientale.

14. Preparation of the made-to-order approach for DRC in order to resolve DRC specific vaccination problems.

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

1. Generally speaking, encountered as major problems: the unavailability of HSS funds in the 65 Health Zones, three PHD and four Directions (2, 4, 5 and 7) and one health program (EVP) as called for in their 2013 Operational Action Plans for the following reasons: the granting **sometimes late by AGEFIN to the beneficiaries both nationally and provincially; difficulties correctly preparing the quality requests by the Health Centers, Health Zones, Provincial Health Division and other central level beneficiaries; missing or insufficient communication between Health Zones, Provincial Health Divisions and Provincial AGEFIN; finally long process for awarding procurement contracts taking 3 to 6 months for acquisitions, rehabilitations, various purchases for Health Zones, branches, EVP Coordination, PHD, Health Directions and Programs, especially the resupply of vaccines, medicines, fuel, lubricant and vehicle maintenance**

2. More specifically, as related to the EVP:

a) The routine strategies insufficiently implemented in the health zones;

b) The specific strategies for reaching often difficult to access children were not organized especially in the Health Zones with armed conflicts and without support;

c) System for catching up with dropouts by the Community Relays not implemented in several health zones

d) Performance rate of training supervision remains below 25%;

e) Less than 60% of the health areas organize monthly monitoring meetings for action;

f) Small proportion of peripheral level staff trained in EVP management

g) Resurgence of measles epidemics in the health zones

j) Irregularity of disbursements of financing for transporting vaccines and supplies from the branches to the health zones

**Pathways for solutions for improving future HSS fund results:**

1. **Generally:**

By strengthening technical monitoring of project implementation, regularly organizing ad hoc committee sessions conforming to the recommendations of the Aide-Memoire signed May 2011 between the MPH and GAVI Alliance, joint assignments to the provinces, meeting the results reporting schedules (45 days after the end of the quarter), meeting the funds disbursement intervals (each half year), strengthening the MST unit for awarding procurement contracts. Finally by promoting a constructive partnership between the players in the sector, strengthening communication, tompro and tommonotoring software management, and financial management capacities and preparing quality requests

2. **Specifically** as it involves the **HSS impact on vaccination coverage**, this plan proposes activities which should be able to strengthen operationally the application of the RED approach.

These activities are: (i) support planning in the health areas with community participation on the vaccination services bottlenecks;

(ii) support organization of vaccination sessions at least two times per week in each health area by fixed, forward and mobile strategy

(iii) support organization in each health area of a quarterly EVP training supervision;

(iv) support organization of EVP data monitoring each month in the Health Zones by the Health Zone management team;

(v) support the purchase of social mobilization services supporting vaccination in the 65 Health Zones by civil society organizations through relevant performance contracts related to the recovery of children lost from view and/or located in difficult to access health areas and also preschool consultations for children from 0 to 49 months).

Additionally, the intermediate level (healthcare districts and provincial branches of the expanded vaccination program) are also supported in order to strengthen their capacity to provide the organization and supervision of the vaccination services in the Health Zones. The operation of these structures, training of trainers/advisors for the health zones, semiannual or annual quality data reviews, performance bonuses and supervision are considered in connection with this 2012 and 2013 HSS plans.

The national Expanded Vaccination Program management is also supported in the areas of preparing standards and guidelines, performing annual reviews, training for strengthening abilities, participation in other international seminars, national and international consultation, performance bonuses, technical coordination committee meetings, national healthcare information system activities, vaccine transport in the various provinces, and purchasing of hardware and equipment for strengthening both the central, provincial and peripheral cold chain.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

The main provisions for monitoring and evaluating each level are described in detail in the document Framework for Monitoring and Evaluating the National Health Development Plan 2011-2015. Mainly it involves:

1. For the central level:

**Monthly Meetings of the NSC Committees:**

These are thematic type meetings which handle problems which hinder the implementation of the health system or HSSS strengthening strategy. There are six committees, including among others: Study and planning, management and rationalization of human resources. A Central Director presides over each committee; the members are middle managers and experts from the Ministry of Public Health and the pertinent decisions made are discussed and approved in the Technical Coordination Committee TCC Meetings over which the General Secretary for Health presides.

**TCC Quarterly Meetings**

The members are the central directors and the partners from the health and related fields sector. These are meetings which approve all major decisions for strengthening the health sector; their decisions are brought to the NSC to be adopted.

**National Meeting of the National Steering Committee:**

Once per year, with the possibility of an extra, exceptional meeting. This meeting is held under the patronage of his excellency the Minister of Health and gathers all of Central Directors for directions and programs, partners from the sector, Provincial Inspector Physicians, and Provincial Ministers of Health and also other middle managers and targeted experts.

**Once Yearly Health Sector Reviews:**

This meeting evaluates the activities of the past year for the entire sector and its makeup is comparable to the NSC.

**Periodic Program Reviews:**

Each program for the sector around its managers and partners evaluates the performance level of its program via the SWOT method and take steps for improving the execution of the sector's objectives through this program.

A similar situation applies to periodic surveys such as the demographic and health survey (DHS) and the MICS which are done every five years in order to measure several indicators including impact indicators such as maternal and infantile mortality, etc.

1. For the provincial level

The description of these various meetings follows the example of the central level, but with the managers, experts and partners from this level.

* Monthly meeting of the commissions from the technical secretariat of the Provincial Steering Committees (PSC);

* Quarterly meetings of provincial steering committees;

* Semiannual meetings of the PSC;

* Provincial Annual reviews once per year;

* Periodic review of program coordinators.

For the peripheral level (Health Zone):

1. * Monthly monitoring of data in the Health Zones for preparing the monthly report for the National Healthcare Information System (NHIS)

* Monitoring action for vaccination in each health area by the community relays and the RN under the supervision of a member of the Health Zone office

* Monthly meetings of the health zone management councils;

* Meetings of the Board of Directors for the health zone twice a year: in the first quarter for approving the health zone action plan and the fourth quarter for evaluating the activities from the year

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

There is a single monitoring and evaluation framework for the health sector as described above. The HSS monitoring and evaluation activities are aligned along this framework. There are no HSS monitoring and evaluation activities which are done outside of those called for in the sector monitoring and evaluation framework. The data needed for preparing the HSS reports are collected in connection with the sector monitoring and evaluation activities For example, these activities are:

1. In the health zones the monitoring of activities is done monthly whereas in the healthcare districts it takes place at a quarterly rhythm. During these meetings, the health zones present their data and receive feedback from the managers from the healthcare district and other health zones.

2. Provincially, they hold two semiannual reviews each year (July and February). These semiannual reviews are done in connection with the Provincial Committee for Provincial Steering.

3. An annual review is held each year in the capital. All the provinces participate in this review. These national reviews are organized in connection with the NSC-HS.

The main sources of information used in the periodic reviews at the various levels of the national health system are made up of:

- The data from the National Healthcare Information System (NHIS) analyzed during various provincial health reviews, the national health sector review, the various meetings of the National Steering Committee of the Health Sector (NSC-HS), the NSC-HS Technical Coordination Committee and the GAVI HSS Ad Hoc Committee.

- The monthly, quarterly and annual EVP reports;

- The reports from the various periodic surveys (MICS, DHS and the joint UNICEF and WHO report

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EVP and Civil Society Organizations). Please indicate the type of organization, its name and its function in the implementation process.

In the DRC, the Health Sector Coordinating Committee is called the National Steering Committee for the Healthcare Sector (NSC-HS). This committee was created by Ministerial order number 1250

/CAB/MIN/079/N0V/2009 of November 3, 2009 covering creation, organization operation of the National Steering Committee for the Healthcare Sector in DRC. At its core it comprises the Technical Coordination Committee (TCC) of the NSC-HS, per Article 5, Paragraph 2 of said order. The NSC-HS includes managers from the Ministry of Health from the central and intermediate levels and the main partners from the health sector including civil society at all levels of the Health System.

For the daily management of the HSS proposal, the NSC has delegated power to six members including: **one member from the ministerial cabinet, the Secretary-General for Health, the Director of the DEP, Representatives from WHO and UNICEF and one delegate from Groupe Inter Bailleurs Santé (GIBS).** They gather around the Secretary-General in a **commission referred to as ad hoc** for ruling on any disbursement or problem calling for the opinion of one or the others and decisions made consensually.

**The Civil Society Organizations (CSO) participates in implementing the GAVI-HSS proposal at three levels of the DRC healthcare pyramid:**

**At the central level:** they participate in the meetings of the NSC-HS in order to share in the decision making and strategic directions for implementing the proposal. They have participated in the brainstorming for the mass vaccination campaigns against polio which is ravaging the DRC full force.

**Provincially**: CSO contribute technical and management support in the implementation of the project, especially in the planning process and the popularization of the HSSS and their active participation in the PSC meetings.

**Operationally** (Health Zones), the CSO are the true field agents. Typically they work with the targeted health zones to which they provide technical and logistical support in implementing field activities. Through their Representatives (the Community Organizers or CO), they participate in meetings of the Management Council and Health Zone Administration; they motivate the population for visiting the health services in general and the vaccination service in particular through community relays. These Community Liaisons with their RED and/or AVI approach catch-up all the targeted children who have not responded to the appointment and because of that need motivation. It's for all these reasons the service providers' contracts for service with precise indicators are signed for further improving access to the offer of vaccination services in 65 healthcare areas under GAVI HSS support.

Furthermore, to achieve the objectives for the whole project, the CSO are even more essential because they know the environment and the context in which the project is taking place and their contribution to the success of a program is always desirable The additional participants in the implementation of the HSS in the country are: the National Council of Health Organizations in DRC (CNOS), the Red Cross of the Congo and the Health in Rural Environment or SANRU

9.4.6. Please describe the participation of Civil Society Organizations in the implementation of the HSS proposal. Please provide names of organizations, type of activities and funding provided to these organizations from the HSS funding.

The CSO are true field agents. Typically they work with the targeted health zones to which they provide technical and logistical support in implementing field activities. Through their Representatives (the Community Organizers or CO), they participate in meetings of the Management Council and Health Zone Administration; they motivate the population for visiting the health services in general and the vaccination service in particular through community relays. These Community Liaisons with their RED and/or AVI approach catch-up all the targeted children who have not responded to the appointment and because of that need motivation. They actively participate in the monitoring action in the health zones for intervention. The CSO have signed the contract with the MPH on HSS funds: the National Council of Health Organizations in DRC or abbreviated CNOS and the Red Cross of the Congo for a contractual amount in 2013 of **$334,928** of which $33,493 is management cost.

9.4.7. Please describe the management of HSS funds and include the following:

- Has the management of HSS funds has been effective?
- List constraints to internal fund disbursement, if any.
- List actions taken to address any issues and to improve management.
- Are any changes to management processes planned for the coming year?

1. Yes monitoring GAVI-HSS funds has become more and more efficient since the MST and KPMG joined the dance in January 2012 as stipulated in the memo of understanding which had called for establishing a financial management agency, **"AGEFIN" and its 29 coordinations and branches throughout the country,** in order to manage the funds transparently, consensually and with mutual responsibility. {

2. Obstacles to internal disbursement of funds in 2013:

(i) late sending of funds from central AGEFIN to provincial AGEFIN and from provincial AGEFIN to the beneficiary Health Zones and PHD;

(ii) Difficulties correctly preparing the quality requests by the beneficiaries;

(iii) No and/or insufficient regular communications between the AGEFIN and the beneficiaries;

(iv) No favorable opinion from AGEFIN before any signature of the contract awarding procurements

(v) lack of banks in most of the communities for smoothly transferring funds to beneficiaries.

(iv) Long distances average 300 km between the health zones and provincial AGEFIN; AGEFIN has neither motorcycle nor vehicle for traveling and supporting the activities under this financing worse in the District of Tanganyika, Sud et Nord Ubangui

(v) Burden in handling requests with AGEFIN and distrust between AGEFIN and PHD

(iv) Mitigated operation of the temporary committee instituted in the MST for coordination of activities after suspension of the National Coordinator.

3. Among the measures taken: Strengthen the skills of the Ministry of Health experts in financial management, preparation of quality requests, signing performance contracts with Provincial Financial Management Agencies and bank transfers of funds in place and instead of financial messaging. Involvement of AGEFIN in the process of awarding procurement contracts in light of the recommendations from amendment II signed July 2013 between MPH and KPMG. Provide the provincial AGEFIN with motorcycles and vehicles to make their travel in the Health Zones easier. Finally launch the recruitment process for new MST coordinator by call for candidacies

4. As change called for to improve the management procedures for the next year: improvement of the communication between the agencies and the beneficiaries by installing communication by website; involvement of all 26 provincial health divisions playing the role of payment initiators with the MST at the central level via signatures or performance contracts between the General Secretary for Health and the 26 Provincial Health Divisions; opening other financial management agency branches and coordinations at least three overall for bringing AGEFIN even closer to the health zones. Organization of after-the-fact controls in the AGEFIN by Financial General Inspector (IGF) and/or Audit Courts (CDC).

## 9.5. Planned HSS activities for 2014

Please use **Table 9.4** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

**Table 9.4:** Planned Activity for 2014

| **Major Activities** (insert as many rows as necessary) | **Planned Activity for 2014** | **Original budget for 2014 (**as approved in the HSS proposal or as adjusted during past annual progress reviews) | **2014 actual expenditure** (as at April 2014) | **Revised activity** (if relevant) | **Explanation for proposed changes to activities or budget** (if relevant) | **Revised budget for 2014** (if relevant) |
|---|---|---|---|---|---|---|
| Activity 1.1. | Support monthly operation of the National Steering Committee | 0 | 2100 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested | 2100 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | (technical administrative office) | | | | rescheduling activities for 2014 | |
| Activity 1.6 | Preparation of central and intermediate level standards (support central and intermediate level reorganization according to new organic framework in the health sector (establish new PHD, captivation and health programs)) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 212150 |
| Activity 1.7 | Organize the study of the end-to-end supply chain in DRC | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 275400 |
| Activity 1.10 | Assignment to support preparation of OAP in the provinces | 0 | 10969 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 156000 |
| Activity 1.12 | Tracking OAP implementation in the provinces | 0 | 64330 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 108377 |
| Activity 1.14 | Participation in international seminars (World Assembly) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 30000 |
| Activity 1.15 | NSC-HS commission meetings | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 9000 |
| Activity 1.17 | National Steering Committee meeting (room and board per diem for participants coming from 11 provinces for three days) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 30000 |
| Activity 1.18 | Establish and operate the HS and RHS observatory | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities | 8750 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | for 2014 | |
| Activity 1.19 | Purchase two computers for project management | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 2569 |
| Activity 1.20 | Purchase photocopiers for project management | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 10000 |
| Activity 1.22 | Acquire Internet installation Kit (VSAT) for Health Zones and PHD | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 460000 |
| Activity 1.26 | Quarterly TCC-HS meeting | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 5000 |
| Activity 1.27 | Organize national sector review (room and board per diem for participants coming from 11 provinces for three days) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 30000 |
| Activity 1.28 | Short-term technical assistance/national consultancy/internal audit | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 30065 |
| Activity 1.31 | Organize two person international assignment | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 17685 |
| Activity 1.32 | International training on contractualization: awarding procurement contracts, monitoring and evaluation and project management | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 20000 |
| Activity 134 | Training on health system research | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 4000 |
| Activity 1.35 | International course on | 0 | 0 | | project thought to reach its end December 31 | 32934 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | health economics and planning | | | | 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | |
| Activity 1.36 | Support central level EVP operation (fuel cold chain, vaccine transport, training etc., tracking assignments in field, performance bonuses central level EVP managers) | 0 | 157670 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 2982000 |
| Activity 1.37 | Evaluation of HSS coming to completion (HSS 1) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 282847 |
| Activity 1.39 | DEP Extension | 0 | 194693 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 194693 |
| Activity 1.40 | Joint assignments in the Health Zones (MPH and TFP: once per quarter) | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 431200 |
| Activity 2.1 | Preparation of Operational Action Plans (OAP) for the targeted provinces: Bas Congo, Kinshasa and S-Kivu | 0 | 46976 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 75000 |
| Activity 2.3 | Supervision (accompanying) of 516 Health Zones by the Provincial Health Divisions (one accompaniment mission per quarter per Health Zone) | 0 | 12491 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 980400 |
| Activity 2.10 | PHD Internet connection | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 931 |
| Activity 2.14 | PHD computer equipment purchases | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested | 53735 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | rescheduling activities for 2014 | |
| Activity 2.15 | Purchase PHD photocopiers | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 61736 |
| Activity 2.17 | Support for quarterly data self-evaluation activities in targeted Health Zones (monitoring, tracking and evaluation) of 26 PHD | 0 | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 156000 |
| Activity 2.18 | Organize semiannual reviews of Provincial Health Divisions | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 250000 |
| Activity 2.19.1 | Monthly operating cost for three target provinces (Bas Congo, Kinshasa and Sud Kivu | | 7530 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 24000 |
| Activity 2.20 | Monthly meetings of PSC committees for three target provinces Bas Congo, Sud Kivu and Kinshasa | | 2135 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 18000 |
| Activity 2.20.1 | Bimonthly meetings of PSC committees for three target provinces Bas Congo, Sud Kivu and Kinshasa | | 588 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 7062 |
| Activity 2.24 | Quarterly performance monitoring in 65 Health Zones | | 7714 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 160180 |
| Activity 2.25 | Monthly operation of 26 PHD | | 3761 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 78000 |
| Activity 2.26 | Support intermediate level EVP activities through 26 PHD | | 280244 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 810650 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Activity 3.1 | Preparation of Operational Action Plans for Health Zones (OAP HZ) | | 66498 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 229638 |
| Activity 3.2 | Rehabilitation/ construction of Health Centers | | 5236 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 2163252 |
| Activity 3.5 | Equip Health Centers with furniture | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 270000 |
| Activity 3.8 | Support for GRH operation and Health Zone Management Teams | | 28449 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 76001 |
| Activity 3.12 | Provide Health Zones with outboards (remainder for purchase of two hulls for Dekese and Kiri Health Zones outboard motors) | | 0 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 22500 |
| Activity 3.14 | Improve drinking water sources in the Health Zones | | 3690 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 82773 |
| Activity 3.15 | Health Center supervision by Health Zone Management Team | | 56451 | | December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 49400 |
| Activity 3.16 | Medication working capital for the GRH including the monitoring and evaluation assignments connected with contracts signed between MPH and | | 16995 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 515000 |
| Activity 3.17 | Medication working capital for the health centers including the monitoring and evaluation assignments connected with contracts signed between MPH and FEDECAME | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 515000 |
| Activity 3.18 | Support routine vaccination | | 0 | | project thought to reach its end December 31, 2013 but considering | 671006 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | activities in the 516 Health Zones (implement RED approach, forward strategy component/quarter/health zone | | | | the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | |
| Activity 3.19 | Raise awareness of Red Cross volunteers and members of base community organizations via CNOS for raising awareness for vaccination and children lost from view according to DRC vaccination schedule | | 17982 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 42028 |
| Activity 3.20 | Strengthen the capacities of community members for raising awareness for routine EVP and recovering children lost from view | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 177425 |
| Activity 3.21 | Support action monitoring meetings in 15 GAVI HSS health areas/health zones via Red Cross volunteers and CNOS members | | 10988 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 57330 |
| Activity 3.22 | Organize monitoring visits to 26 PHD for confirming progress of activities and expected results | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 37229 |
| Activity 3.23 | Research on health systems (action or operational research in the health zones) | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 40000 |
| Activity 4.4 | Training on logistics & health economics & health program evaluation for new managers PHD & health zone under GAVI | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 319800 |
| Activity 4.6 | Training on | | 3128 | | project thought to reach | 18000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | the health system Sud Kivu PHD | | | | its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | |
| Activity 4.7 | Training on health research system Sud Kivu PHD | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 18000 |
| Activity 4.8 | Training on contractualization, awarding procurement contracts Sud Kivu PHD | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 18000 |
| Activity 4.11 | Bonuses for PCT and PSC members in three PHD Sud Kivu, Bas Congo and Kinshasa | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 4554 |
| Activity 4.12 | Quarterly performance bonuses for management team members of the 65 Health Zones | | 89948 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 2025010 |
| Activity 4.14 | Quarterly performance bonuses for Health Center workers in 65 targeted Health Zones | | 122972 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 1168405 |
| Activity 4.15.1 | Quarterly performance bonuses for Provincial Health Division management team members and Vaccine Managers in provinces | | 8100 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 577200 |
| Activity 4.15 | Performance bonuses for vaccine warehouse managers in the PHD | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 192984 |
| Activity 4.16 | Quarterly performance bonuses for division managers (2, 4, 5 and 7) | | 7788 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 24000 |
| Activity 4.18 | Quarterly performance bonuses for staff from | | 18540 | | project thought to reach its end December 31, 2013 but considering the remaining balance | 93750 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | health science establishments being reformed (ITM and IEM) | | | | the IRC had in August 2013 requested rescheduling activities for 2014 | |
| Activity 4.19 | Quarterly performance bonuses for support staff from four target divisions | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 30600 |
| Activity 5.1 | Short-term national technical assistance | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 25000 |
| Activity 5.2 | International consultancy | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 55000 |
| Activity 6.2 | External audit | | 15660 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 60000 |
| Activity | KPMG management fee (10%) | | 8370 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 1241666 |
| Activity 6.3 | MPH/MST management fees (3%) | | 50936 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 581912 |
| Activity 6.4 | Professional fees for AGEFIN services unpaid in 2013 | | 0 | | project thought to reach its end December 31, 2013 but considering the remaining balance, the IRC had in August 2013 requested rescheduling activities for 2014 | 148903 |
| | | 0 | 1322932 | | | 19561830 |

## 9.6. Planned HSS activities for 2015

Please use **Table 9.6** in order to indicate the activities planned for 2015. If you want to make changes to your activities and your budget, please explain the reasons in the table below and support each change, such that the IRC can recommend approval of the revised activities and budget.

**Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes**

**Table 9.6:** Planned HSS Activities for 2015

| Major Activities (insert as many rows as necessary) | Planned Activity for 2011 | Original budget for 2012 (as approved in the HSS proposal or as adjusted during past annual progress reviews) | Revised activity (if relevant) | Explanation for proposed changes to activities or budget (if relevant) | Revised budget for 2012 (if relevant) |
|---|---|---|---|---|---|
| | the project is thought to come to completion December 31, 2013 which is why no activities are planned in 2015. GAVI recommended that we submit a new HSS round 2 proposal in May for 2014 to 2019; the preparation process is nearly at an end. | | | | |
| | | 0 | | | |

## 9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so at any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

## 9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

| Donor | Amount US$ | Duration of support | Type of activities funded |
|---|---|---|---|
| British Department for international development (DFID) | 56,000,000 | five years from 2013-2018 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| Canadian International Development Agency | 3,500,000 | three years from 2013 to 2016 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| Japanese International Cooperation Agency (JICA) | 20,318,939 | This project ended in 2013 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| Belgian Technical Cooperation | 41,568,235 | ended in 2013 and its extension is being renegotiated | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| The Global Fund, Malaria | 31,000,000 | five years 2012-2016 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| The Global Fund, HSS | 8,681,527 | five years 2012-2016 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| The Global Fund, Tuberculosis | 9,324,986 | five years 2012-2016 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| National Health Development Plan Project Support (PAPNDS) | 21,000,000 | four years from 2010 to 2014 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |

| | | | |
|---|---|---|---|
| Congolese Government Project on health center equipment | 85,000,000 | three years from 2013 to 2016 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |
| Prosani/USD | 75,000,000 | five years in 2010 to 2015 | strengthen the three levels of the Health System (Central Level, Intermediate Level and operation) |

9.8.1. Is GAVI's HSS support reported on the national health sector budget? **No**

## 9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

| Data sources used in this report | How information was validated | Problems experienced, if any |
|---|---|---|
| TCC-HS and Ad Hoc Commission minutes in 2013 and also various 2007 DHS surveys, CSO annual report and 2013 MST & KPMG & provinces annual report | Ad Hoc Commission meeting | No issues |
| 2013 or NSC annual sector review meeting minutes | annual sector meeting | No issues |
| various reports of assignments in the sector | assignment debriefing meetings | No issues |
| 2013 extracts of MPH main and AGEFIN secondary bank accounts | Ad Hoc Commission Meeting and Technical Coordination Committee-Health System meeting | No issues |
| Revised 2012-2015 cMYP | IACC Technical meeting | No issues |
| 2013 EVP Annual Report | program and sector annual review | Inconsistency of central EVP administrative data and other sources (Health Zones, UNICEF and WHO) |
| WHO/UNICEF Joint Reporting Form | IACC Technical meeting | No issues |
| Various 2013-2014 provincial review reports | annual Provincial Steering Committee meeting | No issues |
| National Health Information System report | national sector review | data reliability |

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

The conversion of dollars into local currency, Congolese francs, give several figures in billions of Congolese francs and all these digits to not fit in the space provided in the box, hence we couldn't put in these digits for consistency.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013? 6

Please attach:

1. Minutes of HSSS meetings in 2014 which endorsed the present **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

# 10. Strengthened Involvement of Civil Society Organizations (CSOs): Type A and Type B

## 10.1. TYPE A: Support to strengthen coordination and representation of CSOs

The Democratic Republic of the Congo (Kinshasa) **did not receive GAVI support for Type A CSO**.

The Democratic Republic of the Congo (Kinshasa) is not presenting a 2013 report on GAVI support for Type A CSO.

## 10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

**This section is to be completed by countries that have received GAVI TYPE B CSO support**

Please list any abbreviations and acronyms that are used in this report below:

ARCC: Association of Rotary Clubs of the Congo

HA: Health Area

BCG: Calmette and Guérin Bacillus

BCZ: Central Health Zone Office

BDOM: Diocesan Office of Medical Works

IACC: Interagency Coordinating Committee

CNOS: National Council of Health NGO

NSC: National Steering Committee

CODESA: Health Development Committee

MC: Management Committee

COP: Chief of Party

CRRDC: Red Cross of the Democratic Republic of the Congo

HC: Health Center

VC: Vaccination Coverage

DEP: Consulting and Planning Division

DTP: Diphtheria, Tetanus, and Pertussis Vaccine

ECC: Église du Christ au Congo

HZMT: Health Zone Management Team

GAVI: Global Alliance for Vaccines and Immunization

GRH: General Referral Hospital

RN: Registered Nurse

BCO: Base Community Organization

MDG: Millennium Development Goals

NGO: Nongovernmental Organization

CSO: Civil Society Organization

cMYP: Comprehensive Multi-Year Plan

DRC: Democratic Republic of the Congo

RECO: Community Relay

HSS: Health System Strengthening

MV: Measles Vaccine

TTV: Tetanus Toxoid Vaccine

10.2.1. **Program implementation**

Briefly describe progress with the implementation of the planned activities. Please specify how they have supported the implementation of the GAVI HSS proposal or cMYP (refer to your proposal). State the key successes that have been achieved in this period of GAVI Alliance support to CSOs.

The implementation of activities in 2013 rested on for strategic avenues:

**- Raising awareness and catching up with children and pregnant mothers.**

**- Strengthening the functionality of community participation structures**

**- Strengthening of the participation of local NGO/targeted BCO in vaccination activities**

**- Advocacy with political decision-makers (both central and provincial level governments and parliaments)**

As related to these actions, the following progress has been accomplished:

- 1619 RECO/CRRDC volunteers were trained in EVP communication and are active in catching up with unvaccinated children or those who dropped out of sight;
- A little more than 501 BCO identified to date whose members were trained and are working to raise awareness and catch up through communication plans agreed on with the Health Zones;
- The organizers and community relays have been supported by awareness raising kits

- Image boxes (6300),

- megaphones + batteries (1270)

- 33 video forum kits (one rear screen video projector and one projection screen, one DVD player, one 21 inch television, one sound amplifier and two speakers, one 2.5 kVA generator, one regulator and one multi-outlet extension cord).

- Production of distinctive signs (6700 T-shirts and kepi) for motivating community players
- Strong involvement of RECO/volunteers from the CRRDC and BCO in raising awareness during AVW (African Vaccination Week in April 2013 and NVD in July 2013);
- 26 radio stations under contract broadcasting awareness raising messages in the HZ at least once each week and confirmed by listening clubs formed in the HA;
- In the 33 supported HC, the community (RECO/volunteers from the CRRDC and BCO) participate in monthly monitoring meetings both in the HA and in the BZCS;
- RECO/CODESA/BCO organize prevaccination visits (before vaccination sessions) to households in order to identify children and pregnant women to be vaccinated
- Also, advocacy sessions were conducted in three provinces out of five having led in particular to the commitment on transporting vaccines to Kasai and the signing of a social pact in the province between various provincial players (Government, Assembly, Civil Society, EVP) supporting vaccination financing
- With these efforts it was possible to recover 70.975 unvaccinated and or lost from site children and

29,598 unvaccinated pregnant women which serves to increase the vaccination coverage;

The following successes were recorded throughout this period.

Conforming to the objectives set by the project those of reaching 90% for BCG, DTP-HepB-Hib 3, OPV3 and 85% for measles, yellow fever and TT+; The vaccination coverages for all 33 Health Zones from January to December 2003 were as follows: 93% for BCG, 91% for DTP-HepB-Hib 3; 92% for OPV3; 89% for measles and 94% for TT 2+.

Although we have not reached the objectives set for the BCG, DTP-HepB-Hib 3 and OPV3 antigens, the vaccination coverages have increased and are changing positively thus, at the beginning of the project the coverages for these antigens were respectively 96%, 82% and 81%.

This progress was made possible because of various activities conducted by players in the field (HCM T, healthcare providers, etc.) but also following commitment and involvement of the community (members of the BCO and base community structures: CODESA).

By considering the Health Zones classification by category, the following success can be seen: 20 of 33 health zones are classified in category 1; moved from six health zones in category 4 to 1 health zone; Moved from nine health zones in category 1 to 20 health zones.

Please report all major problems (including delays in implementation of activities), and indicate how they were resolved. Please also identify the lead organisation responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

1. Implementation of Activities:

-Delocalization of intervention health zones which leads to additional management costs (setting up new teams in the field);

-Delay for completeness and promptness in sending reports (program and financial)

-Insufficient funds for close by monitoring of Health Zones:

2. Schedule

-Poor accompaniment of health zones management teams by branches because of lack of means for performing supervisory missions for activities

-Low accompaniment of CODESA by the Health Zone Management Teams and irregularity of the RNs from the HA at monthly HZ monitoring meetings following the isolation and overly long distances between the HA and the Health Zones Central Office

Please state whether the GAVI Alliance support to Type B CSO has resulted in a change in the way that CSOs interact with the Ministry of Health, and/or the way they interact with each other.

The structures for community participation revolve around two major entities: CODESA and the Community-Based Organizations, BCO.

The CODESA are traditional organizations which accompany the Health Zones from the day after the establishment of Primary Healthcare. Reformed, these days CODESA are made up of Community Relays, people whose origin is in the community (respectable men from villages or neighborhoods, with recognized opinions, altruistic, etc.) and institutions (people designated by institutions like schools, acting on the basis their commitments supporting the collective interest).

These days, the CODESA are organized in committees at the head of which is a President, Vice President, Secretary and Treasurer; they are active in Health activities including vaccination.

The BCO, community-based organizations are varied and exist for their own purposes, ordinarily religious; there are also some Denominational NGO. In each Health Zone, the BCO are organized in a network (at least

five BCO/HZ) and work in synergy with the CODESA/RECO and Red Cross Volunteers.

These two community participation structures work in synergy and are sufficiently appropriate for vaccination activities to the extent that they have become indispensable to vaccination in the Health Zones. They constitute a real link between the Community and the Health services.

With this support the CSO have also been able to participate in monthly health zone and HA reviews where activities from the past month or evaluated and activities for the current month scheduled. This is an important element because the participation of the Civil Society Organizations in these types of meetings makes it possible for them to have their voice heard while giving a perspective on the operation

Please specify whether the support has led to a change in the level and type of involvement by CSOs in vaccination and health systems strengthening (give the current number of CSOs involved, and the initial number).

Through GAVI Alliance support to Type B CSO, the community actively participates in vaccination activities and health system strengthening. With this support, 1619 RECO/Red Cross Volunteers were trained in communication for EVP and are active in catching up with unvaccinated or lost from sight children; A few more than 501 BCO identified to date whose members were trained and are in that sense operational; in the 33 supported Health Zones, the community (RECO/Red Cross Volunteers, BCO) participate in monthly monitoring meetings both with the HA and also the Health Zone Central Offices; The RECO/CODESA/BCO organize prevaccination visits (before vaccination sessions) in households in order to identify children and pregnant women to be vaccinated; About **70,975 children** unvaccinated and lost from sight and **29,598 pregnant women** have been recovered.

Please outline any impact of the delayed disbursement of funds may have had on implementation and the need for any other support.

With the annual Disbursement, this project has not experienced problems from the financial perspective, nonetheless, the delocalization of the Health Zones has resulted in late start up of activities because it was first necessary to do inventories of these new Health Zones.

Please give the names of the CSOs that have been supported so far with GAVI Alliance Type B CSO support and the type of organization. Please state if were previously involved in vaccination and / or health systems strengthening activities, and their relationship with the Ministry of Health.

For each CSO, please indicate the major activities that have been undertaken, and the outcomes that have been achieved as a result. Please refer to the expected outcomes whose list appears in the proposal.

**Table 10.2.1a:** Outcomes of CSOs activities

| Name of CSO (and type of organisation) | Previous involvement in vaccination/HSS | GAVI supported activities undertaken in 2013 | Outcomes achieved |
|---|---|---|---|
| ARCC (NGO) | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Train members of CODESA (RECO) and the Red Cross Volunteers in EVP communication.<br>- Strengthen the skills of the organizers of the identified BCO in management of their structures and in communication for EVP<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers | 610 CODESA/RECO members are trained in communication for EVP<br>- The skills of 68 organizers of BCO are strengthened.<br>- 9085 children and 7301 pregnant women are recovered<br>- The CODESA raise awareness; The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization.<br>- The BCO raise community awareness on basis of communication plan.<br>- The community players meet once per quarter to exchange experience<br>- The HZMT perform monthly tracking of monthly CODESA activities monthly do the monthly following<br>- The local NGO meet each quarter for sharing experience. |

| | | | |
|---|---|---|---|
| | | and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | |
| CNOS (NGO) | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Train members of CODESA (RECO) and the Red Cross Volunteers in EVP communication.<br>- Strengthen the skills of the organizers of the identified BCO in management of their structures and in communication for EVP<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness | 160 CODESA/RECO members are trained in communication for EVP<br>- The skills of 200 organizers of BCO are strengthened.<br>- 9085 children and 7301 pregnant women are recovered<br>- The CODESA raise awareness The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization.<br>- The BCO raise community awareness on basis of communication plan.<br>- The community players meet once per quarter to exchange experience<br>- The HZMT perform monthly tracking of monthly CODESA activities monthly do the monthly following<br>- The local NGO meet each quarter for sharing experience.<br>- 139 political decision-makers reached by advocacy sessions |

| | | | |
|---|---|---|---|
| | | raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience<br>4. Advocacy with political decision-makers (both central and provincial level governments and parliaments)<br>- Organize advocacy with political decision-makers in provincial government and provincial assemblies from Katanga, Kasaï occidental, Kasaï oriental, Province orientale and Équateur provinces | |
| CRRDC | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Train members of CODESA (RECO) and the Red Cross Volunteers in EVP communication.<br>- Strengthen the skills of the organizers of the identified BCO in management of their structures and in communication for EVP<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness | 168 CODESA/RECO members are trained in communication for EVP<br>- The skills of 200 organizers of BCO are strengthened.<br>- 9661 children and 2040 pregnant women are recovered<br>- The CODESA raise awareness The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization.<br>- CODESA meetings<br>- The BCO raise community awareness on basis of communication plan.<br>- The community players meet once per quarter to exchange experience |

| | | | |
|---|---|---|---|
| | | raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | - The HZMT perform monthly tracking of monthly CODESA activities monthly do the monthly following<br>- The local NGO meet each quarter for sharing experience. |
| SANRU | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Train members of CODESA (RECO) and the Red Cross Volunteers in EVP communication.<br>- Strengthen the skills of the organizers of the identified BCO in management of their structures and in communication for EVP<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness raising of households through media and listening clubs for | - 651 CODESA/RECO members are trained in communication for EVP<br>- The skills of 45 organizers of BCO are strengthened.<br>- 29,594 children and 6182 pregnant women are recovered<br>- The CODESA raise awareness The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization.<br>- CODESA meetings<br>- The BCO raise community awareness on basis of communication plan.<br>- The community players meet once per quarter to exchange experience<br>- The HZMT perform |

| | | | |
|---|---|---|---|
| | | areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>- Reproduce and distribute distinctive signs (T-shirt, kepi, etc.) for motivating community relays and BCO members.<br>- Reproduce and provide community relays and BCO with materials for raising awareness and reporting (megaphones, image boxes, recommendation cards, notebooks, reporting sheets, etc.)<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | monthly tracking of monthly CODESA activities monthly do the monthly following<br>- The local NGO meet each quarter for sharing experience.<br>- The organizers and community relays have been supported by awareness raising kits 6300 image boxes, 1270 megaphones + batteries 33 video forum kits |

Please list the CSOs that have not yet been funded, but are due to receive support in 2013/2014, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if are currently involved in vaccination and / or health systems strengthening.

Please also indicate the new activities to be undertaken by those CSOs already supported.

**Table 10.2.1b:** Planned activities and expected outcomes for 2013/2014

| Name of CSO (and type of organization) | Current involvement in vaccination/HSS | Activities which should be undertaken in 2013/14 with GAVI support | Expected outcomes |
|---|---|---|---|
| ARCC (NGO) | YES | 1. Raising awareness and | Children and pregnant women |

| | | | |
|---|---|---|---|
| | | catching up with children and pregnant mothers.<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | not reached by the vaccination service are recovered. Listening clubs are working. The actors from CODESA raise awareness in public places. The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization. The local NGO/identified BCO raise community awareness. The CODESA meet each month for the progression of their activities. The HA monitoring meetings are organized each month. The community players (community relays) and BCO from the HZ gather each quarter for sharing experience. The HZMT regularly perform tracking of the CODESA. The forward strategies are organized in the HA. Awareness is raised based on quarterly plans for their communication prepared in collaboration with the HZ. The local NGO/BCO in the HZ meet once per quarter to exchange experience. |
| CNOS | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness | Children and pregnant women not reached by the vaccination service are recovered Listening clubs are working. The actors from CODESA raise awareness in public places. The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization. The local NGO/identified BCO raise community awareness |

| | | | |
|---|---|---|---|
| | | raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience<br>4. Advocacy with political decision-makers (both central and provincial level governments and parliaments)<br>- Organize advocacy with political decision-makers in provincial government and provincial assemblies from Katanga, Kasaï Occidental, Kasaï Oriental, Province Orientale and Équateur Provinces | The CODESA meet each month for the progression of their activities. The HA monitoring meetings are organized each month. The community players (community relays) and BCO from the HZ gather each quarter for sharing experience. The HZMT regularly perform tracking of the CODESA. The forward strategies are organized in the HA. Awareness is raised based on quarterly plans for their communication prepared in collaboration with the HZ. The local NGO/BCO in the HZ meet once per quarter to exchange experience. The provincial political decision-makers are reached by the advocacy. |
| CRRDC | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness | Children and pregnant women not reached by the vaccination service are recovered Listening clubs are working. The actors from CODESA raise awareness in public places. The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization. The local NGO/identified BCO raise community awareness |

| | | | |
|---|---|---|---|
| | | raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | The CODESA meet each month for the progression of their activities. The HA monitoring meetings are organized each month. The community players (community relays) and BCO from the HZ gather each quarter for sharing experience. The HZMT regularly perform tracking of the CODESA. The forward strategies are organized in the HA. Awareness is raised based on quarterly plans for their communication prepared in collaboration with the HZ. The local NGO/BCO in the HC meet once per quarter to exchange experience. |
| SANRU | YES | 1. Raising awareness and catching up with children and pregnant mothers.<br>- Support raising awareness of households and/or recovering unvaccinated or insufficiently vaccinated children and pregnant women by RECO and Red Cross Volunteers during home visits (nearby awareness raising)<br>- Support awareness raising of households through media and listening clubs for areas not covered by radio waves.<br>- Support awareness raising in public spaces by actors from CODESA (Community Relays, Red Cross Volunteers and Opinion Leaders).<br>- Support awareness raising by RECO and Red Cross Volunteers during activities | Children and pregnant women not reached by the vaccination service are recovered Listening clubs are working. The actors from CODESA raise awareness in public places. The RECO and Red Cross Volunteers raise awareness during activities requiring mass mobilization. The local NGO/identified BCO raise community awareness. The CODESA meet each month for the progression of their activities. The HA monitoring meetings are organized each month. The community players (community relays) and BCO from the HZ gather each quarter for sharing experience. The HZMT regularly perform tracking of the CODESA. The |

| | | | |
|---|---|---|---|
| | | requiring mass mobilization (e.g. AVI, mass campaigns, African Vaccination Week, etc.)<br>- Support organization of awareness raising sessions by local NGOs/identified BCO<br>2. Strengthening the functionality of community participation structures<br>- Support monthly organizations of CODESA meetings<br>- Support, monthly, Health Area monitoring meetings<br>- Support, quarterly, organization of assemblies of community players (community relays) and BCO at the Health Zone level.<br>- Support monitoring of CODESA by the HZMT (monitoring and communication with the community).<br>- Support forward strategies<br>3. Strengthening of the participation of local NGO/targeted BCO in vaccination activities<br>- In collaboration with the HZMT, support preparation of communication plans for the local NGO/BCO in the Health Zones<br>- Support awareness raising activities of the local NGO/BCO in the Health Zones<br>- Support organization of meetings of local NGO/BCO in the Health Zones for exchanging experience | forward strategies are organized in the HA. Awareness is raised based on quarterly plans for their communication prepared in collaboration with the HZ. The local NGO/BCO in the HC meet once per quarter to exchange experience. |

10.2.2. **Future of CSO participation in the health systems, health sector planning and vaccination**

Please describe the participation of the CSO in planning future activities and implementing health systems and vaccination related activities Document and summarize the CSO plans for participation in this process including options and financing figures if possible.

If the country plans to use the Health System Financing Platform, please describe the commitment of the CSO to this process.

In connection with GAVI support, the CSO have reframed their actions in the same space as HSS at the request of the Ministry of Health. Furthermore, the actions are currently focused on community related activities.

The Civil Society Organizations (CSO) participate in implementing the GAVI-HSS proposal at three levels of the DRC healthcare pyramid:

At the central level: they participate in the meetings of the NSC-HS in order to share in the decision making and strategic directions for implementing the proposal. The CSO work in collaboration with the EVP with which they share the implementation planning and progress through the IACC and also through other meetings organized by the EVP (e.g. EVP midcourse or annual review, preparation of the annual status report, etc.) during which vaccination related problems are debated.

They have participated in the brainstorming for the mass vaccination campaigns against polio which is ravaging the DRC full force.

Provincially: the CSO provide their technical and management support in the project implementation, especially in the planning process and the HSSS rollout and their active participation in the monthly technical Interagency Coordination Committee (IACC) meetings, quarterly PHD, HD reviews and the semiannual meetings of the health sector provincial steering committees (PSC). They also work in collaboration with the

EVP branches in the planning of activities (routine, AVI and SVA), joint monitoring of Health Zone level activities,

Operationally (Health Zones), the CSO are the true field agents. Typically they work with the targeted health zones to which they provide technical and logistical support in implementing field activities. Through their Representatives (the NGO especially the denominational ones because they have community level implications, base community organizations (BCO), health area development committees (CODESA)), they participate in Health Zone and Health Area management Council and Administration meetings; they encourage the population to make use of health services in general and vaccination in particular through community relays and Red Cross Volunteers. These Community Liaisons with their RED and/or AVI approach catch-up all the targeted children who have not responded to the appointment and because of that need motivation. It's for all these reasons the service providers' contracts for service with precise indicators are signed for further improving access to the offer of vaccination services in 65 healthcare areas under GAVI HSS support.

The CSO are going to regularly strengthen the communication activities in the community in order to inform and raise awareness and thereby reduce certain socio-cultural barriers to the health area development committees (CODESA) and the identified Base Community Organizations (BCO) and thus through the media.

Furthermore, to achieve the objectives for the whole project, the CSO are even more essential because they know the environment and the context in which the project is taking place and their contribution to the success of a program is always desirable

**10.2.3.** Please name the CSO active in the implementation and the contact information of their representatives.

ARCC: key project contact: Dr. Valentin Mutombo, bbmichaelmutombo@outlook.fr
CNOS: key project contact: Mr. Emmanuel Nyabenda, cnosrdc@yahoo.fr

CRRDC: key project contact: Dr. Jean Faustin Balelia, jbalelia@yahoo.fr

SANRU: Key contact for the coordination unit: Dr. Benoit MIBULUMUKINI, benoitmibul@sanru.org

key project contact for implementation: Dr. Assy LALA, assylala@sanru.org

ARCC: ARCC President: Mr. Ambroise Tshimbalanga,

CNOS: CNOS President: Mr. Nestor Mukinay, cnosrdc@yahoo.fr

CRRDC: CRRDC President: Mr. Dominique Lutula, presidentcrrdc@yahoo.fr

SANRU: SANRU Director: Dr. Ngoma Miezi Kintaudi, leonkintaudi@sanru.org

10.2.4. **Receipt and Expenditure of Type B CSO Funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for Type B CSO funds for the 2013 year.

| | Amount ($US) | Amount local currency |
|---|---|---|
| Funds received during 2013 (A) | 2,330,000 | 2,143,600 |
| Remaining funds (carry forward) in 2012 *(B)* | 76,659 | 70,910 |
| Total funds available in 2013 (C=A+B) | 2,406,659 | 2,214,510 |
| Total Expenditures in 2013 (D) | 1,752,112 | 1,620,703 |
| Carry over to 2014 (E=C-D) | 654,547 | 593,807 |

Is GAVI's support to Type B CSO reported on the national health sector budget? **No**

Briefly describe the financial management arrangements and process used for your Type B CSO funds your country received. Indicate whether Type B CSO funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of Type B CSO funds, such as delays in availability of funds for program use.

*Please include details on: the type of bank account(s) used (business or government account); budget approval process; way funds are directed to sub-national levels; provisions for preparing national and sub-*

*national level financial reports; and the global role of HSSS in the process.*

For 2013, the CSO received direct financing from GAVI and received it annually.

The management is done based on signed memoranda between the CSO and the COP and based on the procedures manual prepared by the consortium.

The program CSO file their quarterly requests for funds with the COP and the disbursement to them is done according to the budget by means of a financial report and conditional on the documentation of a consumption of at least 80% of the funds previously received; a request for funds using the form is intended for that purpose.

Any rearrangement of the budget or any other unplanned operation requires the backing of the COP after undergoing a competitive exam between the COP and the CSO. Each CSO was responsible for its management, but COP handles tracking the management of each CSO in the consortium and having compliance with the procedures.

The project activities are done in the provinces, the consortium's CSO also use the funds transfer agencies present in various provinces in order to get the funds to provincial coordinators of the CSO who handle getting it to the HZ.

The provincial coordination offices send to the national level of each CSO of the consortium all the supporting documents for the activities conducted at their level. Thus, each CSO from the consortium prepares a financial report and subsequently sends it to the coordination unit of the consortium COP which finally produces a consolidated report for the Project.

Problems encountered:

- During transfer of funds from the GAVI account to the COP bank account, an amount of order US$4,659.99 was retained as a fee which led to a budget overrun on the bank fee budget line item of order 7.99% for the COP.
- Since the banks are not represented in all the provinces, the funds transfer for the field activities by means of transfer agencies leads to an increase of the bank fees.

**NB:**

The CNOS and CRRDC NGO received GAVI/HSS funds. In fact, the CNOS signed a collaboration contract with the Ministry of Public Health for improving the involvement of the populations in vaccination activities.

Quarterly the CNOS receives funds for activities from the Financial Management Agency (AGEFIN) via the Ministry of Health Management Support Team (MST). The funds for activities to strengthen the skills of the community organizers and for monitoring activities are paid directly into the account of CNOS open at the TMB (Trust Merchants Bank) in Kinshasa. The funds for awareness raising support activities and supporting monitoring activities in health areas are directly paid by AGEFIN into the provinces and health zones which are financing beneficiaries.

The CNOS in turn orders a bank transfer of funds to the Red Cross based on a request for funds according to the work plan prepared in cooperation with the CNOS

The financial management reports are prepared by each entity receiving them: for the transferred funds coming directly from AGEFIN in the health zones, the CNOS branches in the health areas document it directly with the provincial AGEFIN and retain copies for the central level CNOS for information;

the Red Cross sends the financial report for activities performed directly to CNOS central level which consolidates all the financial reports and sends them finally to the Ministry of Health AGEFIN. To have access to financing for the following quarter, 80% of the expenditures from the preceding quarter must have been documented.

Detailed expenditure of Type B CSO funds during the 2013 calendar year

Please attach a detailed financial statement for the use of Type B CSO funds during the 2013 calendar year

**(**Document number). The financial reports will be signed by the main civil servant responsible for Type B CSO funds.

**Has an external audit been conducted? Yes**

**External audit reports for HSS programs are due to the GAVI Secretariat six months following the close of your government's fiscal year. If an external audit report is available during your government's most recent fiscal year, this should also be attached (Document Number).**

10.2.5. **M&E**

Please give details of the indicators that are being used to monitor performance; outline progress in the last year (baseline value and current status), and the targets (with dates for achievement).

These indicators must appear in the CSO application and reflect what appears in the cMYP and/or GAVI HSS proposal.

**Table 10.2.5: Progress of CSOs Project Implementation**

| Activity / outcome | Indicator | Data Source | Baseline Value and date | Current status | Date recorded | Objective | Date for Target |
|---|---|---|---|---|---|---|---|
| Support awareness raising activities by the O | Number of awareness raising sessions held | Activity report | 2087 | 1824 | December 31, 2013 | 2078 | December 31, 2013 |
| Support organization of meetings of local NGO | Number of local NGO meetings in the Health Zones | Activity report | 99 | 87 | December 31, 2013 | 99 | December 31, 2013 |
| Support awareness raising of households through | Number of spots and/or shows broadcast | Activity report | 930 | 719 | December 31, 2013 | 930 | December 31, 2013 |
| Support raising awareness of households and/or | Number of children ≤ 12 years old recovered | Activity report | 105606 | 70975 | December 31, 2013 | 105606 | December 31, 2013 |
| Support raising awareness of households and/or | Number of pregnant women recovered | Activity report | 35224 | 29598 | December 31, 2013 | 35224 | December 31, 2013 |
| Support raising awareness of households and/or | DTP3 vaccination coverage rate | Activity report | 90% | 91% | December 31, 2013 | 90 | December 31, 2013 |
| Support raising awareness of households and/or | Measles vaccination coverage rate | Activity report | 87% | 89% | December 31, 2013 | 87 | December 31, 2013 |
| Support raising awareness of households and/or | TT2+ vaccination coverage rate | Activity report | 87% | 94% | December 31, 2013 | 87 | December 31, 2013 |
| Support raising awareness of households and/or | Number of base CSO participating in activities | Activity report | 165 | 172 | December 31, 2013 | 165 | December 31, 2013 |
| Support awareness raising by RECO and Red Cross Volunteers | Number of awareness raising sessions organized | Activity report | 4310 | 4814 | December 31, 2013 | 4310 | December 31, 2013 |
| Support monitoring of CODESA by the HZMT | Number of CODESA monitoring visits done by | Activity report | 396 | 279 | December 31, 2013 | 396 | December 31, 2013 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Support monthly organizations of meetings | Number of CODESA meetings | Activity report | 5229 | 3381 | December 31, 2013 | 5229 | December 31, 2013 |
| In collaboration with the HZMT, support prep | Number of local NGO communication plans | Activity report | 99 | 99 | December 31, 2013 | 99 | December 31, 2013 |
| Support monthly monitoring meetings | Number of Health Area monitoring meetings | Activity report | 5229 | 3844 | December 31, 2013 | 5229 | December 31, 2013 |
| Support, quarterly, organization of assem | Number of community assemblies in | Activity report | 99 | 87 | December 31, 2013 | 99 | December 31, 2013 |
| Train members of CODESA (RECO) and the Red Cross | Number of CODESA members trained Number of volun | Activity report | 1737 | 1619 | December 31, 2013 | 1737 | December 31, 2013 |
| Organize advocacy with political decision-makers | Number of Decision-Makers reached by sessions | Activity report | 136 | 139 | December 31, 2013 | 136 | December 31, 2013 |
| Strengthen the skills of the organizers of the identified BCO | Number of BCO organizers trained | Activity report | 165 | 449 | December 31, 2013 | 165 | December 31, 2013 |
| Reproduce and distribute distinctive signs (T- | Number of distinctive signs reproduced and Number | Activity report | 6700 | 6700 | December 31, 2013 | 6700 | December 31, 2013 |
| Reproduce and provide community relays and | Number of image boxes reproduced, Number of | Activity report | 6300 | 6300 | December 31, 2013 | 6300 | December 31, 2013 |
| Reproduce and provide community relays and | Number of megaphones purchased, Number of megaphones | Activity report | 1270 | 1270 | December 31, 2013 | 1270 | December 31, 2013 |

**Planned activities:**

Please describe in detail the mechanisms that are being used to monitor these indicators, including the role of beneficiaries in monitoring the progress of activities, and how often this occurs. Indicate any problems experienced in measuring the indicators, and any changes proposed.

1. A the community level: The main beneficiaries participate directly in tracking indicators through the community relay network, their representatives at the CODESA and COGE meetings and other monitoring encounters organized at the health zone or health area level. The health area level monitoring meetings are held monthly.

2. Peripheral Level (Health Area and Health Zone):

The activities taking place in the Health Areas, the monthly meetings in the Health Areas bringing together registered nurses, assistants and community players (CODESA/RECO, Red Cross Volunteers and BCO) constitute the first level of performance monitoring and orientation; during these meetings, the community players present reports on their activities for confirmation.

At the Health Zone level, outside the HZMT supervisory visits to the HA, the monthly meetings between the HZMT and registered nurses constitute an opportunity not only for evaluating performance but also for training by sharing experience of nurses who have problems.

Quarterly the HZMT also organize meetings with the local NGO/BCO in the Health Zones for exchanging

experience.

At this level the project tracking indicators are:

- DTP3, measles and TT2+ vaccination coverage rate by health area

- Number of unvaccinated children recovered per health area

- Number of unvaccinated women recovered per health area

- Number of base CSO participating in vaccination activities per health area

-Number of awareness raising sessions organized

-Number of home visits made by RECO and Red Cross Volunteers.

-Number of quarterly meetings organized at the Health Zone level with participation of community players

3. Intermediate Level (EVP Branch)

Quarterly EVP Branch-HZMT meetings with which, beyond data consolidation, to analyze:

performance of each of the Health Zones and to formulate recommendations

Additionally, in order to help the Health Zones perform better, accompaniment of the Health Zones is done through joint monitoring assignments of the EVP branches/Health Districts and the provincial coordinations of the CSO.

The project tracking indicators are:

- DTP3, measles and TT2+ vaccination coverage rate by health zone

- Number of unvaccinated children recovered per health zone

- Number of unvaccinated women recovered per health zone

- Number of base CSO participating in vaccination activities per health zone

- Proportion of the project's health zones with over 80% coverage

4. At the central level

The provincial coordinations of the CSO of the consortium perform monthly tracking of the activities in the Health Zones and Health Areas and the central level of each CSO does quarterly tracking. The COP organizes the consortium's quarterly meetings and midcourse reviewin order to update and uncover difficulties encountered, propose paths for solutions and share the way in which these difficulties were overcome and exchange experiences and lessons learned among each other. The CSO also participate in various IACC meetings.

The project tracking indicators are:

- DTP3, measles and TT2+ vaccination coverage rate by health zone

- Number of children not reached recovered by RECO and Red Cross Volunteers.

- Number of children lost from view recovered per HZ

-Number of unvaccinated pregnant women recovered.

- Coverage rate per HZ, by partners and for the project

## 11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included

in the attachments.

# 12. Appendices

## 12.1. Annex 1 – VSS Instructions

INSTRUCTIONS:

FINANCIAL STATEMENTS **FOR THE NEW VACCINE INTRODUCTION GRANT** IN THE CONTEXT OF **VACCINATION SERVICES SUPPORT (VSS)**

I. All countries that have received a new vaccine introduction grant/VSS during the 2013 calendar year, or had a remaining financing balance in 2013 from a new vaccine introduction/VSS grants, are required to submit financial statements for these program as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

Funds carried forward from the 2012 calendar year (opening balance as of 1 January 2013)

Income received from GAVI during 2013

Other income received during 2013 (interest, fees, etc.)

Total expenditure during the calendar year

Closing balance as of December 31, 2013

A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarize total annual expenditures for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries). Cost categories will be based on your government's own system of economic classification. Please give the budget for each expenditure line item at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each expenditure line item as of 31 December 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these financial statements should be examined during the external audit for the 2013 financial year. Audits for VSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.2. Annex 2 – Example VSS Income & Expenditure

MINIMUM REQUIREMENTS FOR **FINANCIAL STATEMENTS FOR VSS** AND VACCINE INTRODUCTION GRANT 1

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI VSS** | | |
|---|---|---|
| | **Local Currency (CFA)** | **Value in $USD*** |
| **Carried forward from 2012** (balance on December 31, 2012) | 25,392,830 | 53,000 |
| **Summary of income received during 2013** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Interest income | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total income** | 38,987,576 | 81,375 |
| **Total expenditure in 2013** | 30,592,132 | 63,852 |
| **Balance as at 31 December 2013** (balance carried forward to 2014) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| Detailed analysis of expenditure by economic classification ** – GAVI HSS | | | | | | |
|---|---|---|---|---|---|---|
| | Budget in CFA | Budget in US$ | Actual spending in CFA | Actual spending in $US | Variance in CFA | Variance in USD |
| **Salary expenditure** | | | | | | |
| Wages & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance and overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditure** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2013** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 12.3. Annex 3 – Terms of reference HSS

INSTRUCTIONS:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I.All countries that have received HSS funds during the 2013 calendar year, or had remaining balances in 2013 of previously disbursed HSS funding, are required to submit financial statements for these programs as part of their Annual Progress Report.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

Funds carried forward from the 2012 calendar year (opening balance as of January 1, 2013)

Income received from GAVI during 2013

Other income received during 2013 (interest, fees, etc.)

Total expenditure during the calendar year

Closing balance as of December 31, 2013

A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis should summarize total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by applicable line item (for example:. wages & salaries). Cost categories will be based on your government's own system of economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditures during the calendar year, and the balance remaining for each objective, activity and cost category as of December 31, 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these financial statements will be examined during each country's external audit for the 2013 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS SUPPORT FINANCIAL STATEMENTS**:

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI HSS** | | |
|---|---|---|
| | **Local Currency (CFA)** | **Value in $USD*** |
| **Carried forward from 2012** (balance on December 31, 2012) | 25,392,830 | 53,000 |
| **Summary of income and expenditure – 2013** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Interest income | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total revenues** | 38,987,576 | 81,375 |
| **Total expenditure in 2013** | 30,592,132 | 63,852 |
| **Balance on December 31, 2013** (carried forward to 2014) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| **Detailed analysis of expenditure by economic classification ** – GAVI HSS** | | | | | | |
|---|---|---|---|---|---|---|
| | **Budget in CFA** | **Budget in US$** | **Actual spending in CFA** | **Actual spending in $US** | **Variance in CFA** | **Variance in USD** |
| **Salary expenditure** | | | | | | |
| Wages & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance and overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditure** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2013** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 12.5. Annex 5 – Terms of reference CSO

INSTRUCTIONS:

FINANCIAL STATEMENTS FOR **SUPPORT TO CIVIL SOCIETY ORGANIZATIONS (OSC)** TYPE B

I. All countries that have received grants for support to 'Type B' CSO during the 2013 calendar year, or had remaining balances in 2013 of previously disbursed 'Type B' CSO funding, are required to submit financial statements for these programs as part of their Annual Progress Report.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2013 calendar year, which will include points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2012 calendar year (opening balance as of January 1, 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc.)

Total expenditure during the calendar year

e. Closing balance as of December 31, 2013

A detailed analysis of expenditures during 2013, based on your government's own system of economic classification. This analysis is to summarize total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' support proposal, with further breakdown by expenditure line item (for example: wages & salaries). Cost categories will be based on your government's own system of economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditures during the calendar year, and the balance remaining for each objective, activity and cost category as of December 31, 2013 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements will be examined during each country's external audit for the 2013 financial year. Audits for "Type B" CSO are due to the GAVI Secretariat 6 months following the close of each country's financial year.

## 12.6. Annex 6 – Example CSO Income & Expenditure

MINIMUM REQUIREMENTS FOR **FINANCIAL STATEMENTS FOR SUPPORT TO 'Type B' CSO**:

*An example statement of income & expenditure*

| **Summary of income and expenditure – GAVI CSO** | | |
|---|---|---|
| | **Local Currency (CFA)** | **Value in $USD*** |
| **Carried forward from 2012** (balance on December 31, 2012) | 25,392,830 | 53,000 |
| **Summary of income received during 2013** | | |
| Income received from GAVI | 57,493,200 | 120,000 |
| Interest income | 7,665,760 | 16,000 |
| Other income (fees) | 179,666 | 375 |
| **Total revenues** | 38,987,576 | 81,375 |
| **Total expenditure in 2013** | 30,592,132 | 63,852 |
| **Balance on December 31, 2013** (balance carried forward to 2014) | 60,139,325 | 125,523 |

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

| **Detailed analysis of expenditure by economic classification ** – GAVI CSO** | | | | | | |
|---|---|---|---|---|---|---|
| | **Budget in CFA** | **Budget in US$** | **Actual spending in CFA** | **Actual spending in $US** | **Variance in CFA** | **Variance in USD** |
| **Salary expenditure** | | | | | | |
| Wages & salaries | 2,000,000 | 4,174 | 0 | 0 | 2,000,000 | 4,174 |
| Per diem payments | 9,000,000 | 18,785 | 6,150,000 | 12,836 | 2,850,000 | 5,949 |
| **Non-salary expenditure** | | | | | | |
| Training | 13,000,000 | 27,134 | 12,650,000 | 26,403 | 350,000 | 731 |
| Fuel | 3,000,000 | 6,262 | 4,000,000 | 8,349 | -1,000,000 | -2,087 |
| Maintenance and overheads | 2,500,000 | 5,218 | 1,000,000 | 2,087 | 1,500,000 | 3,131 |
| **Other expenditure** | | | | | | |
| Vehicles | 12,500,000 | 26,090 | 6,792,132 | 14,177 | 5,707,868 | 11,913 |
| **TOTALS FOR 2013** | 42,000,000 | 87,663 | 30,592,132 | 63,852 | 11,407,868 | 23,811 |

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

## 13. Attachments

| Document Number | Attachment | Section | Mandatory | File |
|---|---|---|---|---|
| 1 | Minister of Health Signature (or delegated authority) | 2.1 | ✓ | Page signature Ministre de la S<br>**File desc:** Minister of Health a<br>**Date/time:** May 15, 2014 08:4<br>**Size:** 136 KB |
| 2 | Minister of Health Signature (or delegated authority) | 2.1 | ✓ | Page signature Ministre des F<br>**File desc:** Minister of Finance page<br>**Date/time:** May 15, 2014 08:4<br>**Size:** 136 KB |
| 3 | ICC member signatures | 2.2 | ✓ | Page signature CCIA.pdf<br>**File desc:** IACC member sign<br>**Date/time:** May 15, 2014 08:5<br>**Size:** 171 KB |
| 4 | Minutes of the ICC meeting in 2014 that endorsed the 2013 APR | 5.7 | ✓ | Compte rendu de la réunion d'<br>RSA 2013 GAVI.doc<br>**File desc:** Minutes of the mee<br>12, 2014 which endorsed the 2<br>**Date/time:** May 14, 2014 03:1<br>**Size:** 1 MB |
| 5 | HSCC member signatures | 2.3 | ✓ | Page signature CCSS.pdf<br>**File desc:** HSCC member sig<br>**Date/time:** May 15, 2014 08:5<br>**Size:** 164 KB |
| 6 | Minutes of the HSCC meeting in 2014 that endorsed the 2013 APR | 9.9.3 | ✓ | Compte rendu de la réunion d'<br>RSA 2013 GAVI.doc<br>**File desc:** Minutes of the mee<br>12, 2014 which endorsed the 2<br>**Date/time:** May 14, 2014 03:1<br>**Size:** 1 MB |
| 7 | Financial statement for VSS grant (fiscal year 2013) signed by Chief Accountant or by the Permanent Secretary of Ministry of Health | 6.2.1 | ✗ | Section non applicable pour la<br>**File desc:**<br>**Date/time:** May 13, 2014 02:0<br>**Size:** 29 KB |
| 8 | External report audit on VSS grant (fiscal year 2013) | 6.2.3 | ✗ | Section non applicable pour la<br>**File desc:**<br>**Date/time:** May 13, 2014 02:0<br>**Size:** 29 KB |

| | | | | |
|---|---|---|---|---|
| 9 | Post-introduction evaluation report | 7.2.2 | ✓ | Rapport préliminaire PIE RDC 30042014.docx<br>**File desc:** Preliminary Report PCV 13 Introduction in DRC E<br>**Date/time:** May 08, 2014 03:2<br>**Size:** 2 MB |
| 10 | Financial statement for grant for introduction of new vaccine (fiscal year 2013) signed by Chief Accountant or by the Permanent Secretary of Ministry of Health | 7.3.1 | ✓ | RapportComitéAdhocAu31Déc Final du 11 03 14.pdf<br>**File desc:** Financial report on 31, 2013 prepared by AGEFIN approved by the Ad Hoc Comr March 12, 2014 including new (PCV 13) Introduction expendi<br>**Date/time:** May 11, 2014 02:3<br>**Size:** 933 KB |
| 11 | External audit report for grant for introduction of new vaccine (fiscal year 2013), if total expenditures for 2013 were greater than $US 250,000 | 7.3.1 | ✓ | Lettre de Recommandations Provisoire.doc_CAG.doc<br>**File desc:** Provisional report o HSS Audit done by the interna outside auditors Grant Thornto responsible for the 2012 and 2 period audit<br>**Date/time:** May 11, 2014 02:2<br>**Size:** 1 MB |
| 12 | EVSM/EVM report | 7.5 | ✓ | Rapport_ GEV_RDC 2011.doc<br>**File desc:** Implementation lev EVM improvement plan<br>**Date/time:** May 08, 2014 03:3<br>**Size:** 1 MB |
| 13 | Latest EVSM/EVM improvement plan | 7.5 | ✓ | 5. Rapport MEO Plan améliora GEV.docx<br>**File desc:** EVM_DRC improve<br>**Date/time:** May 08, 2014 03:5<br>**Size:** 190 KB |
| 14 | Progress report on EVSM/EVM improvement plan | 7.5 | ✓ | 5. Rapport MEO Plan améliora GEV.docx<br>**File desc:** Implementation lev EVM improvement plan<br>**Date/time:** May 08, 2014 03:5<br>**Size:** 190 KB |
| 16 | Valid cMYP if the country is requesting continued support | 7.8 | ✗ | PPAC RDC 2013-2015_Mercr 2012_VF – Alexis 2.docx<br>**File desc:** Revised 2013-15 R<br>**Date/time:** May 08, 2014 04:4<br>**Size:** 4 MB |

| | | | | |
|---|---|---|---|---|
| 17 | Valid Tool for calculating cMYP costs if the country is requesting continued support | 7.8 | ✗ | DRC_Outil Costing PPAc_13 S OK.xlsx<br>**File desc:** 2013-2015 DRC cM Tool<br>**Date/time:** May 08, 2014 05:4<br>**Size:** 1 MB |
| 18 | Minutes from the ICC meeting approving the extension of support for vaccinations, as needed | 7.8 | ✗ | Non applicable.docx<br>**File desc:** Extension not appli DRC in 2014<br>**Date/time:** May 14, 2014 05:2<br>**Size:** 10 KB |
| 19 | Financial statement for HSS grant (fiscal year 2013) signed by Chief Accountant or by the Permanent Secretary of Ministry of Health | 9.1.3 | ✓ | RapportComitéAdhocAu31Déc Final du 11 03 14.pdf<br>**File desc:** Financial report on 31, 2013 prepared by AGEFIN approved by the Ad Hoc Comm March 12, 2014<br>**Date/time:** May 04, 2014 01:4<br>**Size:** 933 KB |
| 20 | Financial statement for HSS grant for January-April 2014 signed by Chief Accountant or by the Permanent Secretary of Ministry of Health | 9.1.3 | ✓ | Etats Financiers Gavi 2 2014<br>**File desc:** HSS and New Vacc Introduction Financial Stateme 2014<br>**Date/time:** May 15, 2014 12:2<br>**Size:** 478 KB |
| 21 | External audit report for HSS grant (fiscal year 2013) | 9.1.3 | ✓ | Lettre de Recommandations Provisoire.doc_CAG.doc<br>**File desc:** Provisional report o HSS Audit done by the interna outside auditors Grant Thornto responsible for the 2012 and 2 period audit<br>**Date/time:** May 11, 2014 02:2<br>**Size:** 1 MB |
| 22 | Health Sector Review Report – HSS | 9.9.3 | ✓ | Rapport de la reunionCNP-SS mai 2013.doc<br>**File desc:** Minutes of the Mee 2013 DRC National Steering C Health Sector<br>**Date/time:** April 30, 2014 12:3<br>**Size:** 392 KB |
| 23 | Census report – CSO-type A support | 10.1.1 | ✓ | RAPPORT RECENSEMENT.p<br>**File desc:** ,,<br>**Date/time:** May 07, 2014 09:4<br>**Size:** 129 KB |

| | | | | |
|---|---|---|---|---|
| 24 | Financial statement for allocation for CSO-type B support (fiscal year 2013) | 10.2.4 | ✓ | ETATS FINANCIERS OSC GA<br>**File desc:**<br>**Date/time:** May 07, 2014 09:4<br>**Size:** 617 KB |
| 25 | External audit report for CSO-type B support (fiscal year 2013) | 10.2.4 | ✓ | RAPPORT AUDIT 2013.pdf<br>**File desc:**<br>**Date/time:** May 07, 2014 09:4<br>**Size:** 124 KB |
| 26 | Bank statements for each cash program, or consolidated bank statements for all existing cash programs if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) January 1st, 2013 and (ii) December 31st, 2013 | 0 | ✓ | extrait bcaire n°02.pdf<br>**File desc:** Bank statement fro account, for others see main d<br>**Date/time:** May 05, 2014 01:2<br>**Size:** 217 KB |
| 27 | compte_rendu_réunion_ccia_changement_présentation_vaccin | 7.7 | ✗ | Compte rendu de la réunion d' RSA_2013 GAVI_Nestor.docx<br>**File desc:** Minutes of IACC m approving vaccine presentatio<br>**Date/time:** May 14, 2014 05:2<br>**Size:** 500 KB |
| | Other document | | ✗ | Extrait bancaire au 31 Décem OSC GAVI 2013.pdf<br>**File desc:**<br>**Date/time:** May 12, 2014 08:0<br>**Size:** 591 KB<br><br>Compte rendu de la Commisio 12 mars 2014 final nestor 21 m 2014.doc<br>**File desc:** Minutes of the Ad H Commission of March 12, 201 the financial report for the 201 period and the 2014 GAVI acti<br>**Date/time:** May 04, 2014 01:5<br>**Size:** 431 KB<br><br>Compte rendu de la réunion d Commission Ad hoc du 19 nov (2) final.doc<br>**File desc:** Minutes of the GVI Commission adopting the reso concerning Health Center reha with GAVI HSS funds<br>**Date/time:** April 30, 2014 01:2<br>**Size:** 80 KB<br><br>Compte rendu de la Commissi du 5 novembre 2013_nestor (1<br>**File desc:** Minutes of the Ad H Commission meeting of May 1 |

concerning mid-course evalua
2013 GAVI OAP and rehabilita
HC with GAVI HSS funds by U
FDSS
**Date/time:** April 30, 2014 01:1
**Size:** 629 KB

COMPTE RENDU DE LA REU
COMMISSION TECHNIQUE 1
2013_final.pdf
**File desc:** Minutes of the GAV
Technical Commission/Ad Hoc
Commission of March 1 conce
recommendations of the Febru
GAVI assignments
**Date/time:** April 30, 2014 01:0
**Size:** 1 MB

CR- Reunion MSP&PROGOU
2013-REVU.doc
**File desc:** Minutes of the TCC
October 21, 2013 concerning
decentralization and cooperati
management of the DRC healt
**Date/time:** April 30, 2014 12:5
**Size:** 69 KB

CNP SS final avril 2013.doc
**File desc:** Minutes of the April
meeting of the Technical Coor
Committee of the NSC-HS wh
was adopting PHC access pla
central level OAP and roadma
in the sector
**Date/time:** April 30, 2014 12:4
**Size:** 116 KB

CR réunion du CCT sur le pro
selec tion.doc
**File desc:** Minutes of August
Technical Coordination Comm
selection process of Provincial
Division managers concerning
**Date/time:** April 30, 2014 12:5
**Size:** 155 KB

Etat financier compte principal
2014.pdf
**File desc:** Financial statement
main account of the MPH 2013
**Date/time:** May 06, 2014 10:5
**Size:** 69 KB

EXTRAIT bancaire compte se
GAVI AU 01 01 2014 AGEFIN
**File desc:** HSS secondary ba
statement managed by AGEF
showing balances on January
March 31, 2014
**Date/time:** May 08, 2014 02:3
**Size:** 1 MB

EVALUATION FINALE DU RS
synthese.doc
**File desc:** The report summar
HSS 1 evaluation finishing by
UNIKIN/DRC School of Public
2014; the full document exists
**Date/time:** May 05, 2014 01:3
**Size:** 205 KB

Page signature CCSS.pdf
**File desc:** Signature page for
the DRC Civil Society Organiz
**Date/time:** May 15, 2014 09:0
**Size:** 82 KB

Rapport de Mission Indépenda
d.docsynthsese.doc
**File desc:** Summary report of
and institutional structure evalu
connected with the HSS 1 fina
management April 2014
**Date/time:** May 05, 2014 01:5
**Size:** 48 KB

extrait bcaire nÂ°01.pdf
**File desc:** MPH main bank ac
statement 2013-2014
**Date/time:** May 05, 2014 01:4
**Size:** 83 KB

extrait bcaire n°03.pdf
**File desc:** MPH main bank ac
statement 2013-2014
**Date/time:** May 05, 2014 01:4
**Size:** 50 KB