[V1.15.4]

GAVI Alliance

Annual Progress Report 2014

submitted by

the Government of
Democratic Republic of Congo (Kinshasa)

Reporting year: **2014**
Support application for the year: **2016**
Date of presentation: **05/21/2015**

Deadline for submission: 05/27/2015

Please submit the Annual Progress Report 2014 via the online platformhttps://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavi.org or a GAVI Alliance partner representative. Documents may be provided to GAVI partners, their staff, and the general public. The APR and its appendices must be submitted in English, French, Spanish, or Russian.

Note: *Please use previous APRs and approved Proposals for GAVI support as reference documents. Electronic copies of previous annual progress reports and approved requests for support are available at the following address* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to the country. Unless otherwise stated, the documents will be made available to the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMS

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance will be used and applied for the sole purpose of conducting the program(s) described in the Country's application. Any significant change in 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 THIS PROPOSAL

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any changes to the program(s) in the current application. The GAVI Alliance will document any changes that it has approved and the Country's application will be amended accordingly.

REIMBURSEMENT OF FUNDS

The Country agrees to reimburse, to the GAVI Alliance, all funding that is 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 days after the Country receives the GAVI Alliance's request for a reimbursement. The reimbursed funds will be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/CANCELLATION

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 purposes 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 any 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 accept any gifts, payments or benefits directly or indirectly related to this application, that could be construed as illegal or corrupt.

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 their own or through an agent, to perform audits or other financial management assessments 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 keep its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of the GAVI Alliance funds. If there are any claims of misuse of funds, the Country shall 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 Country confirm that this support application is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to conduct the programs described in this application.

CONFIRMATION REGARDING COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy and complies with the requirements therein.

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 the 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 its 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. Arbitration will be conducted in accordance with the UNCITRAL Arbitration Rules in force. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The arbitration will be conducted in Geneva, Switzerland. The arbitration languages will be English or French.

For any dispute for which the amount is US$ 100,000 or less, there will be one arbitrator appointed by the GAVI Alliance. For any dispute for which the amount 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, conflicts of interest, harm to property, or personal injury or death. The country is solely responsible for all aspects of managing and implementing the programs described in this application.

By preparing this APR, the Country will inform GAVI about:

activities conducted using GAVI resources in the past year, significant problems that were

faced and how the country has tried to overcome them

meeting the accountability needs concerning the use of GAVI-disbursed funds and in-country arrangements with development partners for requesting more funds that had been approved in a previous application for ISS/NVS/HSS, but have not yet been released

how GAVI can make the APR more user-friendly while meeting GAVI's accountability and transparency principles

1. Characteristics of the support

Reporting year: **2014**

Support application for the year: **2016**

1.1. NVS AND INS SUPPORT

Type of Support	Current vaccine	Preferred presentation	Active until
New Vaccine Support (routine immunization)	Pneumococcal (PCV13), 1 dose per vial, LIQUID	Pneumococcal (PCV13), 1 dose per vial, LIQUID	2015
New Vaccine Support (routine immunization)	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
New Vaccine Support (routine immunization)	Yellow fever, 10 dose(s) per vial, LYOPHILIZED	Yellow fever, 10 dose(s) per vial, LYOPHILIZED	2015

New Vaccine Support (routine immunization)	IPV, 10 dose(s) per vial, LIQUID	IPV, 10 dose(s) per vial, LIQUID	2018

DTP-HepB-Hib (Pentavalent) vaccine: based on your country's current preferences, the vaccine is available through UNICEF in liquid form in one or ten dose vials and in the liquid/lyophilized form in two-dose vials to be used in a course of three injections. Other presentations have already been pre-selected by WHO and the complete list can be viewed on the WHO website, but the availability of each product should be individually confirmed.

The second preferred presentation of **IPV, 5 dose(s) per vial, LIQUID** IPV:

The third preferred presentation of **IPV, 1 dose(s) per vial, LIQUID** IPV:

1.2. Extension of the Program

Type of Support	Vaccine	Start Year	End Year
New Vaccine Support (routine immunization)	Pneumococcal (PCV13), 1 dose per vial, LIQUID	2016	2016
New Vaccine Support (routine immunization)	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2016	2016
New Vaccine Support (routine immunization)	Yellow fever, 10 dose(s) per vial, LYOPHILIZED	2016	2016
New Vaccine Support (routine immunization)	IPV, 10 dose(s) per vial, LIQUID	2019	2020

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilization in 2014	Request for approval of	Eligible for 2014 ISS reward
Type B CSO	Yes	Extension in support for Type B CSO by a decision of the Board in July 2014: N/C	No
COS	Yes	Not applicable	No
VIG	Yes	Not applicable	No
Subsidy for change in output	Yes	N/C	No
HSS	Yes	next installment of the HSS grant No	No

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous IRC Report

The annual progress report (APR) of the IRC for the year 2013 is available here. French version is also available here.

2. Signatures

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

By signing this page, the Government of the Republic of Congo (Brazzaville), 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 funds 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 Congo (Brazzaville)

Please note that this APR will neither be reviewed or approved by the High-level Review Committee without the signatures of both the Minister of Health & Minister of Finance or their authorized representatives.

Minister of Health (or delegated authority)		**Minister of Finance (or delegated authority)**	
Name	Félix KABANGE NUMBI MUKWAMPA	**Name**	Henri YAV MULANG
Date		**Date**	
Signature		**Signature**	

This report has been compiled by (these persons can be contacted if the GAVI Secretariat has any queries regarding this document):

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2.2. ICC Signatures Page

If the country presents a report on the Immunization Services Support (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, the HSCC and ICC committees are merged into one committee. Please complete each relevant section and upload the signed pages of the attached documents twice, once for HSCC signatures and once for ICC signatures

The GAVI Alliance Transparency and Accountability Policy is an integral part of the GAVI Alliance's monitoring of the country's results. 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 Inter-Agency coordinating Committee (ICC), endorse this report. Signing 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. Félix KABANGE NUMBI Mukwampa / Ministry of Health	Government		
Dr. Deo NSHIMIRIMANA/ Representative	WHO		
Mr. Pascal VILLENEUVE	UNICEF		
Mrs. Meri SINNITT/ Head of the Health Program	USAID		
Mr. Nestor MUKINAY TUM'TUM/ Chairperson	Civil Society Organization (NCNH)		

Dr. Audry MULUMBA/EPI Director	Ministry of Health		

The ICC may wish to send informal comments to: apr@gavi.org. All comments will be treated confidentially. Partners' observations:

Observations of 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. Deo NSHIMIRIMANA, Mr. Pascal VILLENEUVE, Dr. Diana Putman, Dr. Alain MBOKO IYETI , Dr. Jean Pierre LOKONGA, endorse this report on the Health Systems Strengthening Program. Signing 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 the GAVI Alliance's monitoring of the country's results. 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. Deo NSHIMIRIMANA/ Representative	WHO		
Mr. Pascal VILLENEUVE/ Representative	UNICEF		
Dr. MUKENGASHAYI KUPA/ Secretary General for Health	MINISTRY OF PUBLIC HEALTH		
Mrs. Meri SINNITT/ Head of the Health Program	USAID		
Dr. Jean Pierre LOKONGA	WHO		
Dr. Alain MBOKO IYETI/ Director	DIRECTORATE OF STUDIES AND PLANNING / MSP		

The HSCC may wish to send informal comments to: apr@gavi.org. All comments will be treated confidentially. Partners' observations:

Observations of the Regional Working Group:

2.4. Signatures Page for GAVI (Types A & B) support to CSOs

This report has been prepared in consultation with CSO representatives participating in national level coordination mechanisms (HSCC or equivalent and ICC) and those involved in the mapping exercise (for Type A funding), and those receiving support from the GAVI Alliance to help implement the GAVI HSS proposal or cMYP (for Type B funding).

2.4.1. Responsible for the preparation of the Quarterly monitoring report on the support to CSOs

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

Name/Title	Agency/Organization	Signature	Date

2.4.2. Hierarchy 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. Alain IYETI/ Director of DSP	Government		
Mr. Pascal VILLENEUVE / Representative	UNICEF		
Mr. Nestor MUKINAY TUM'TUM/ Chairperson	Civil Society Organizations (NCNH)		

Signing the endorsement 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 Democratic Republic of Congo's (Kinshasa) activities between January - December 2014 and specifies requests for the period January – December 2016

Sections

4. Baseline data and annual targets

Countries are requested to make a realistic evaluation of vaccine wastage, supported by an analysis of data collected at the national level. In the absence of specific data, the country can use the maximum wastage rates given for illustrative purposes in the **Wastage rate Table** appendix of the support request guidelines. Please note the reference wastage rate for the Pentavalent vaccine is available in ten-dose vials.

Please also note that if the country applies the WHO multi-dose vial policy for IPV, the maximum indicative wastage rates are 5%, 15% and 20% for the 1-dose, 5-dose and 10-dose presentations respectively.

Number	Preparation of joint report from the WHO/UNICEF		Objectives (Preferred presentation format)							
	2014		2015		2016		2017		2018	
	Original approved target in accordance with the Decision Letter	Reported	Original approved target in accordance with the Decision Letter	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Total number of births	3,561,876	3,561,875	3,668,732	3,668,732		3,778,794		3,892,158		4,008,923
Total number of infant deaths	454,139	454,139	467,763	467,763		481,796		496,250		511,138
Total number of surviving infants	3,107,737	3,107,736	3,200,969	3,200,969		3,296,998		3,395,908		3,497,785
Total number of pregnant women	3,561,876	3,561,875	3,668,732	3,668,732		3,798,794		3,892,158		4,008,923
Number of infants who received (should receive) BCG vaccine	3,383,782	3,196,913	3,485,296	3,375,234		3,514,279		3,658,629		3,768,387
BCG coverage*[1]*	95%	90%	95%	92%	0%	93%	0%	94%	0%	94%
Number of infants who received (should receive) OPV3 vaccine	2,796,963	2,850,415	2,880,872	2,912,882		3,000,268		3,124,235		3,217,962
OPV3 coverage*[2]*	90%	92%	90%	91%	0%	91%	0%	92%	0%	92%
Number of infants who received (should receive) DTP1 vaccine*[3]*	2,952,350	3,087,335	3,040,920	2,944,891		3,066,208		3,192,153		3,322,896
Number of infants who received (should receive) the DTP3 vaccine *[3][4]*	2,796,963	2,884,121	2,880,872	2,912,882		3,000,268		3,124,235		3,217,962
DTP3 coverage*[2]*	90%	93%	90%	91%	0%	91%	0%	92%	0%	92%
Wastage *[5]* rate during the reference year and anticipated thereafter (%) for the DTP vaccine	10	10	10	10		8		8		6
Wastage *[5]* factor during the reference year and anticipated thereafter for the DTP vaccine	1.11	1.11	1.11	1.11	1.00	1.09	1.00	1.09	1.00	1.06
Number of infants who received (should receive) the 1st dose of DTP-HepB-Hib vaccine	2,921,273	3,087,335	3,040,920	2,994,891		3,066,208				
Number of infants who received (should receive) the 3rd dose of DTP-HepB-Hib vaccine	2,921,273	2,884,121	2,880,872	2,912,882		3,000,268				
DTP-HepB-Hib coverage *[2]*	94%	93%	90%	91%	0%	91%	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%) *[6]*	5	10	10	10		10				

Number	Preparation of joint report from the WHO/UNICEF		Objectives (Preferred presentation format)							
	2014		2015		2016		2017		2018	
	Original approved target in accordance with the Decision Letter	Reported	Original approved target in accordance with the Decision Letter	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Wastage *[5]* factor in the base-year and planned thereafter (%)	1.05	1.11	1.11	1.11	1	1.11	1	1	1	1
Maximum wastage rate for DTP-HepB-Hib vaccine, 10 dose(s) per vial, LIQUID	0%	0%	0%	25%	0%	25%	0%	25%	0%	25%
Number of infants who received (should receive) Yellow fever vaccine	2,796,963	2,363,807	2,880,872	2,880,872		2,967,298				
Yellow fever coverage*[2]*	90%	76%	90%	90%	0%	90%	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%)	40	20	15	20		20				
Wastage *[5]* factor in the base-year and planned thereafter (%)	1.67	1.25	1.18	1.25	1	1.25	1	1	1	1
Maximum wastage rate for Yellow fever vaccine, 10 dose(s) per vial, LYOPHILIZED	0%	40%	0%	40%	0%	40%	0%	40%	0%	40%
Number of infants who received (should receive) the 1st dose of Pneumococcal (PCV13) vaccine	2,828,041	2,677,549	3,040,920	2,944,891		3,066,208				
Number of infants who received (should receive) the 3rd dose(s) of Pneumococcal (PCV13) vaccine	2,545,237	2,304,960	2,880,872	2,912,882		3,000,268				
Pneumococcal (PCV13) coverage*[2]*	82%	74%	90%	91%	0%	91%	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%)	5	5	5	5		5				
Wastage *[5]* factor in the base-year and planned thereafter (%)	1.05	1.05	1.05	1.05	1	1.05	1	1	1	1
Maximum wastage rate for Pneumococcal (PCV13) vaccine, 1 dose(s) per vial, LIQUID	0%	5%	0%	5%	0%	5%	0%	5%	0%	5%
Number of infants who received (should receive) IPV vaccine		0	2,005,181	3,200,969	2,068,542	3,316,998		3,395,908		3,497,785
Wastage *[5]* rate in the base-year and planned thereafter (%)		0	50	50	50	45		40		35
Wastage *[5]* factor in the base-year and planned thereafter (%)	1	1	2	2	2	1.82	1	1.67	1	1.54
Maximum wastage rate for IPV vaccine, 10 dose(s) per vial, LIQUID (see note above)	0%	50%	0%	50%	0%	50%	0%	50%	0%	50%
Number of infants who received (should receive) the 1st dose of Measles Vaccine	2,796,963	2,772,711	2,880,872	2,880,872		2,967,298		3,090,276		3,252,940

Number	Preparation of joint report from the WHO/UNICEF		Objectives (Preferred presentation format)							
	2014		2015		2016		2017		2018	
	Original approved target in accordance with the Decision Letter	Reported	Original approved target in accordance with the Decision Letter	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Measles coverage *[2]*	90%	89%	90%	90%	0%	90%	0%	91%	0%	93%
Pregnant women immunized with TT+	3,205,688	3,134,063	15	3,301,859		3,400,915		3,502,942		3,608,031
TT+ coverage*[7]*	90%	88%	0%	90%	0%	90%	0%	90%	0%	90%
Vit A supplement to mothers within 6 weeks of the delivery	0	0	0	0		0		0		0
Vit A supplement to infants older than 6 months	15,048,926	15,288,638	15,500,394	15,500,394	N/A	15,965,406	N/A	16,444,368	N/A	16,937,699
Annual DTP Drop out rate [(DTP1–DTP3)/DTP1] x100	5%	7%	5%	1%	0%	2%	0%	2%	0%	3%

Number	Objectives (Preferred presentation format)			
	2019		2020	
	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Total number of births		4,129,191		4,253,066
Total number of infant deaths		526,472		542,266
Total number of surviving infants		3,602,719		3,710,800
Total number of pregnant women		4,129,191		4,253,066
Number of infants who received (should receive) BCG vaccine		3,922,731		4,082,944
BCG coverage*[1]*	0%	95%	0%	96%
Number of infants who received (should receive) OPV3 vaccine		3,350,528		3,488,152
OPV3 coverage*[2]*	0%	93%	0%	94%
Number of infants who received (should receive) DTP1 vaccine*[3]*		3,422,583		3,562,368
Number of infants who received (should receive) the DTP3 vaccine *[3][4]*		3,350,528		3,488,152
DTP3 coverage*[2]*	0%	93%	0%	94%
Wastage *[5]* rate during the reference year and anticipated thereafter (%) for the DTP vaccine		6		6
Wastage *[5]* factor during the reference year and anticipated thereafter for the DTP vaccine	1.00	1.06	1.00	1.06

Number	Objectives (Preferred presentation format)			
	2019		2020	
	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Number of infants who received (should receive) the 1st dose of DTP-HepB-Hib vaccine				
Number of infants who received (should receive) the 3rd dose of DTP-HepB-Hib vaccine				
DTP-HepB-Hib coverage *[2]*	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%) *[6]*				
Wastage *[5]* factor in the base-year and planned thereafter (%)	1	1	1	1
Maximum wastage rate for DTP-HepB-Hib vaccine, 10 dose(s) per vial, LIQUID	0%	25%	0%	25%
Number of infants who received (should receive) Yellow fever vaccine				
Yellow fever coverage*[2]*	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%)				
Wastage *[5]* factor in the base-year and planned thereafter (%)	1	1	1	1
Maximum wastage rate for Yellow fever vaccine, 10 dose(s) per vial, LYOPHILIZED	0%	40%	0%	40%
Number of infants who received (should receive) the 1st dose of Pneumococcal (PCV13) vaccine				
Number of infants who received (should receive) the 3rd dose(s) of Pneumococcal (PCV13) vaccine				
Pneumococcal (PCV13) coverage*[2]*	0%	0%	0%	0%
Wastage *[5]* rate in the base-year and planned thereafter (%)				
Wastage *[5]* factor in the base-year and planned thereafter (%)	1	1	1	1
Maximum wastage rate for Pneumococcal (PCV13) vaccine, 1 dose(s) per vial, LIQUID	0%	5%	0%	5%
Number of infants who received (should receive) IPV vaccine		3,602,719		3,710,800
Wastage *[5]* rate in the base-year and planned thereafter (%)		30		30
Wastage *[5]* factor in the base-year and planned thereafter (%)	1	1.43	1	1.43

Number	Objectives (Preferred presentation format)			
	2019		2020	
	Previous estimates in 2014	Current estimates	Previous estimates in 2014	Current estimates
Maximum wastage rate for IPV vaccine, 10 dose(s) per vial, LIQUID (see note above)	0%	50%	0%	50%
Number of infants who received (should receive) the 1st dose of Measles Vaccine		3,350,528		3,451,044
Measles coverage *[2]*	0%	93%	0%	93%
Pregnant women immunized with TT+		3,716,271		3,870,290
TT+ coverage*[7]*	0%	90%	0%	91%
Vit A supplement to mothers within 6 weeks of the delivery		0		0
Vit A supplement to infants older than 6 months	N/A	17,445,830	N/A	17,969,295
Annual DTP Drop out rate [(DTP1–DTP3)/DTP1] x100	0%	2%	0%	2%

[1] Number of infants immunized compared to the number of births

[2] Number of infants immunized out of the total number of surviving infants

[3] Indicate total number of children vaccinated with either the DTP vaccine alone or combined with others

[4] Please ensure that the DTP3 cells are correctly filled in

[5] The formula for calculating a vaccine wastage rate (as a percentage): [(A - B)/A] x 100, whereby: A = the number of doses distributed for use according to the supply 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.

[6] GAVI would also appreciate feedback from countries on feasibility of and interest in selecting and being shipped multiple Pentavalent vaccine presentations (1-dose and 10-dose vials) so as to optimize wastage, coverage, and cost.

[7] Number of pregnant women immunized with TT+ out of the total number of pregnant women

5. General Program Management Component

5.1. Updated Baseline and Annual Targets

Note: Please fill in the table in section 4 “Baseline and Annual Targets” before you continue

The numbers for 2014 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for immunization activities for 2014.** The figures for 2015 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in the previous APR or in the new application for GAVI support 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 the **number of births**

  In 2014, the population data used for planning, ordering vaccines, and calculating indicators was a result of the population of 2013 plus a growth rate of 3%. Thus, the population estimated in 2013 at 86,463,301 inhabitants rose to 89,046,900 inhabitants in 2014. These figures were validated by each province and by the National Coordinating Committee for the fight against diseases (NCC) at the central level.
  Thus, the population of LIVE BIRTHS rose from 3,458,132 inhabitants in 2013 to 3,561,876 inhabitants in 2014.

- Justification for any changes in **surviving infants**

  In 2014, the population data used for planning, ordering vaccines, and calculating indicators was a result of the population of 2013 plus a growth rate of 3%. Thus, the population estimated in 2013 at 86,463,301 inhabitants rose to 89,046,900 inhabitants in 2014. These figures were validated by each province and by the National Coordinating Committee for the fight against diseases (NCC) at the central level.
  Thus, the population of LIVE BIRTHS rose from 3,107,220 inhabitants in 2013 to 3,107,737 inhabitants in 2014.

- Explanation of changes in targets, per vaccine. **Please note that for targets of more than 10%, the results from previous years must be justified.** For the IPV, explanation should also be provided as attachment(s) to the APR for EACH change in target population.

  The change in targets for all the antigens starting 2013 are not in accordance with the new cMYP (2013-2015) which was revised in August 2012. The targets fixed in 2014 took into account the official results achieved in 2013. The vaccine coverage projections 2014 were made on the basis of the results achieved in 2013.

- Justification for any changes in **Wastage by vaccine**

  The country adopted the PENTAVALENT vaccine (DTP-HepB-Hib) with 10-dose vials instead of single-dose vials. This explains the change in the Wastage rate which rose from 5% to 10% for this antigen.

5.2. Monitoring the implementation of the GAVI gender policy

5.2.1. Has sex-disaggregated data on the coverage of DTP3 from administrative sources and/or surveys been available in your country over the past five years? **No, not available**

If yes, please provide us with the latest data available and indicate the year in which this data was collected.

Data Source	Reference Year for Estimates	DTP3 coverage estimate	
		Boys	Girls
Not available	Not available	Not available	Not available

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

Not available

5.2.3. If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data in routine immunization reports? **No**

5.2.4. How were the potential gender-related barriers to the access and implementation of immunization services (for example, mothers having no access to the services, the gender of service provider, etc.) resolved from the program point of view? (For more information on these gender-related barriers, refer to the GAVI "Gender and Immunization" sheet at http://www.gavialliance.org/fr/librairie/)

Not available

5.3. Overall Expenditure and Financing for Immunization

The purpose of **Table 5.3a** is to guide GAVI understanding of the broad trends in the immunization program expenditure and financial flow. Please complete the table using US$.

Exchange rate used	1 US$ = 930

Only enter the exchange rate; do not enter the name of the local currency

Table 5.3a: Overall Expenditure and Financing for Immunization from all sources (Government and donors) in US$

Expenditure by Category	Expenditure Year 2014	Funding source						
		Country	GAVI	UNICEF	WHO	USAID/ IHP	MORMON	Rotary International
Traditional vaccines*	3,758,802	2,414,709	0	1,344,093	0	0	0	0
New and Under-used Vaccines (NVS)**	51,317,560	0	51,317,560	0	0	0	0	0
Injection material (AD syringes and others)	5,641,236	213,303	5,075,363	352,570	0	0	0	0
Cold Chain equipment	4,240,844	0	1,279,206	2,961,638	0	0	0	0
Staff	1,255,137	1,217,787	37,350	0	0	0	0	0
Other routine recurrent costs	15,283,264	0	2,898,276	4,966,950	4,742,173	2,675,865	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	24,587,269	1,793,911	5,339,000	6,868,988	10,446,972	60,388	18,010	60,000
N/A		0	0	0	0	0	0	0
Total Expenditures for Immunization	106,084,112							
Total Government Health expenditures		5,639,710	65,946,755	16,494,239	15,189,145	2,736,253	18,010	60,000

Traditional vaccines: BCG, DTP, OPV, 1st of measles vaccine (or the combined MR, MMR), TT. Some countries will also include Herb and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.4. Inter-Agency Coordination Committee (ICC)

How many times did the ICC meet in 2014? **2**

Please attach the minutes **(Document No. 4)** from the ICC 2015 meeting that endorsed this report.

List the principal concerns or recommendations, if any, made by the ICC on sections 5.1 Reference data and annual targets carried out to 5.3 Overall Immunization Expenditure and Funding

1/2 ICC Strategy meetings whose main recommendations were:

<?xml: namespace prefix = "o" ns = "urn: schemas-microsoft-com: office: office" />

- Contact the DSP to incorporate the immunization data and the data on availability of vaccines and inoculation material per province and antigen, in the scoreboard, for regular monitoring,
- Finalize and share the joint report on the evaluation of the Annual Progress Report GAVI 2013 as well as the proposed schedule for introducing new vaccines to be adopted with all partners,
- Identify GAVI funding in the government funds
- Find mechanisms for encouraging the HZ and the HC

Are any Civil Society Organizations members of the ICC? **Yes**
If yes, which ones?

List CSO members of the ICC:
ROTARY CLUB OF CONGO (RCCA)
NATIONAL COUNCIL OF NGOs (NCNH)
HEALTH FOR ALL IN THE RURAL ENVIRONMENT (SANRU)
RED CROSS OF CONGO

5.5. Priority actions in 2015 to 2016

What are the country's main objectives and priority activities for its EPI program from 2015 to 2016?

5.1. Overall target

<?xml: namespace prefix = "o" />

To contribute to reduction of morbidity and mortality caused due to diseases preventable by immunization

5.2. Specific targets

Vaccine coverage targets 2015

Vaccination coverage target projections based on the administrative data obtained in 2014 is as follows:

BCG : 92%, DTP-HepB-Hib3: 91 %, OPV3: 91%, PCV-13 (3): 91%, MV: 90%, YFV: 90%, VAT2+: 90% and VPI: 47%

Process targets

a) Provision of services
   - Achieve at least 91% VC for DTP-HepB+Hib3 at the national level and at least 80% in each HZ by the end of 2015.
   - Reduce the gap between the administrative vaccine coverage for DTP-HepB+Hib3 and the coverage estimated by the WHO and UNICEF to less than 10% by the end of 2015.
   - Introduce the IPV by end of 2015.

b) Supply, quality of vaccines, and logistics
   - Ensure 100% availability of quality vaccines and other inputs at all levels;
   - Strengthen 100% of the structure with logistics management capacity by providing equipment and staff training.

- Increase the coverage of working cold chain equipment from 16% to 20% in the Health Areas.

c) Supervision
- Achieve surveillance indicators for AFP in terms of certification standards in 26 PHDs;
- Institute an environmental surveillance system for WPV;
- Increase the proportion of HZ having notified at least 1 suspected case of measles from 60% to 80% including a sample;
- Increase the proportion of yellow fever cases notified and investigated, from 50.59 to 100%;
- Increase the investigation rate of NNT cases from 14.6% to 60%.
- Increase the notification of AEFI cases from 1% to 50%.
- Ensure 100% optimal functioning of sentinel sites.

d) Communication
- Encourage the parents to ask for complete immunization of their children of 0-11 months of age, including new vaccines;
- Improve the level of information of parents from 89% to 95% before the mass campaign;
- Make the APA and the leaders at the grassroot level to get involved in supporting the immunization activities;
- Ensure capacities of those involved in communication at the operational level. e) Program management
- Strengthen leadership, partnership, and good governance of the program;
- Increase the State budget for immunization.

In order to achieve the targets fixed, the following main activities were planned for implementation based on the related strategy.

1) Complete implementation of the REA strategy:

- Develop an annual OAP for the central level during the cMYP review;
- Support the annual micro-planning of immunization activities in the 8,830 health areas;
- Mobilize additional funds for implementing traditional and new strategies at the operational level;
- Provide technical support of the intermediate level to the HZ for implementation of the REA approach;
- Implement specific strategies to reach target populations with focus on branches with a high risk of polio;

- Provide financial support in monitoring, from the intermediate level to the 516 HZ, every quarter;
- Provide financial support in monitoring, from HZ to the 8830 health areas;
- Provide technical and financial support for training staff at the operational level in EPI management (MCZ, IS and CW of the 516 HZ);
- Provide technical and financial support for training staff of IT and ITA of the 8,830 HA in EPI management;
- Support in organizing Child Health Days (CHD);

2) Research and development:

- Organize CAP surveys (knowledge, attitudes, and practices) and surveys on vaccine coverage in terms of accessibility and use of immunization services (RO);
- Organize an experience sharing trip with a country that has 1 working NTAGI (National Technical Advisory Group on Immunization);

3) Reach and immunize people who find themselves in an emergency situation (displaced, refugees, returned, deported, etc.):

- Plan for an emergency stock of vaccines for the displaced and the refugees;
- Develop and popularize guidelines related to immunization of emergency cases, displaced people, and refugees;
- Establish collaboration links with departments responsible for the displaced people and the refugees;
- Support multi-antigen immunization in emergency situations

4) Improve the quality of immunization data:

- Revise management tools and data collection tools;
- Develop and popularize the user manuals for EPI management tools and data collection tools;
- Reproduce tools, EPI fact sheets, standards, and guidelines covering the annual requirements;
- Train immunization data managers to build their capabilities to improve data quality in 11 provinces;
- Carry out advocacy efforts to appoint one person in charge of healthcare data management including management of immunization data at each HDCO;
- Provide financial and technical support to the organization of monthly reviews (monitoring) of immunization activities at all levels as per the documentation prepared for standards and guidelines.
- Provide financial and technical support to 26 PHDs in the organization of quarterly reviews;
- Provide financial and technical support to missions to verify the quality of (HSS) data** (DQS, RDQA, Rapid Suitability Monitoring, LQAS and triangulation among MT) (Provincial level);

- Provide technical and financial support in conducting counting activities in the HA of the Health Zones.

5) Train in the introduction of new vaccines:

- Prepare training modules, fact sheets, and publicity pamphlets about the introduction of new vaccines;
- Reproduce revised management tools;
- Ensure training of participants at all levels (IPV)

6) Monitoring and evaluation for introduction of new vaccines:

- Develop monitoring and evaluation tools for pre- and post-introduction evaluation (IPV);
- Organize pre-introduction evaluation of new vaccines;
- Ensure the post-introduction monitoring of new vaccines;
- Organize post-introduction evaluation of new vaccines;

7) Optimization of the vaccines logistics chain:

- Purchase the required vaccine doses and consumables;
- Organize a strategic guidelines workshop in logistics with the logisticians of 26 PHDs based on the vision 2020;
- Organize international technical assistance missions for feasibility studies of the central depot and 3 decentralized depots of Kisangani, Lubumbashi and Ilebo;
- Construct a modern central warehouse at the Ndjili airport with a gross capacity of 2,200 cubic meters of positive storage and 140 cubic meters of negative storage for vaccines;
- Construct a warehouse at the Ndjili airport for dry inputs with a gross volume of 10,000 cubic meters;
- Construct a modern decentralized sub-warehouse at Kisangani with a gross capacity of 480 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of the Eastern part of the country (8 PHDs);
- Construct a dry warehouse at Kisangani with a gross volume of 6,200 cubic meters for the dry inputs of 13 PHDs;
- Construct a modern decentralized sub-warehouse at Lubumbashi with a gross capacity of 160 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of Katanga;
- Construct a dry warehouse at Lubumbashi with a gross volume of 3,030 cubic meters for the dry inputs of PHDs of Katanga;
- Purchase a modern decentralized sub-warehouse at Ibedo with a gross capacity of 320 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of Western and Eastern Kasai;

8) Improvement in the distribution system and transport:

- Purchase 2 cold storage vessels of 480 cubic meters of positive storage, 20 cubic meters of negative storage and a dry storage volume of approximately 1,000 cubic meters each;
- Purchase 5 cold storage vehicles and 16 trucks for transporting vaccines and dry inputs from the central depots and decentralized depots to the 26 PHDs; including transportation from the 26 PHDs to the HZ;
- Purchase 40 vehicles to complement the transport of vaccines, medicines, and other inputs from the PHDs to the HZ;
- Purchase 50 125-type motorcycles for the 50 target HZ;
- Purchase 100 15-HP speedboats and canoes for immunization of riverside children, under specific strategies;
- Purchase 550 100-type motorcycles for advanced strategies in Health Areas with limited accessibility;
- Purchase 1000 canoes for advanced strategies in Health Areas with limited accessibility;
- Ensure transportation of vaccines from the central depot to the PHDs;
- Provide financial support for transportation of vaccines from the PHDs to the HZ

9) Strengthening effective vaccine management through development of resources at all levels:

- Purchase and install continuous temperature monitoring systems (with alarms through SMS) for positive cold rooms of 44 warehouses in PHDs (Branches);
- Purchase 10,000 Freeze-Tags, 100 liberos, 10,000 fridge-tags 2 for monitoring the quality of vaccines;
- Train 35 maintenance engineers in the CC maintenance pools at the central level and the PHDs;
- Train logisticians in the use of inventory tools and material (update mechanism) and conduct SMT and DVD-MT training;
- Organize a training in CCL and in logistics management for the Service Providers in the HZ;
- Organize a training in safety at work for the staff in the Health zones and at the central level.

10) Solar powering of positive cold chains for 44 Branch Depots and Relay Depots:

- Purchase solar-powering materials of a capacity of 40,000 watts to operate the cold chain equipment at the decentralized depot of Ibedo;
- Purchase 88 large-capacity freezers for the PHDs for recycling batteries;
- Purchase and install 300 battery-less solar refrigerators and freezers for 300 HZ;
- Purchase and install 2,000 battery-less (PQS) solar refrigerators of 40 liters for all Health Areas

- Purchase and install 50 incinerators for waste management at 50 HZ

11) Improvement in the quality of SIA:

- Organize quality SIA for Polio;
- Provide technical and financial support in organizing preventive campaigns against yellow fever in 4 provinces;
- Organize a campaign against meningococcal meningitis A in 149 HZ in three target provinces

12) Strengthening active search for cases and community-based surveillance:

- Organize active search missions

13) Strengthening the functioning of polio committees and the INRB laboratory:

- Provide support to the functioning of the INRB laboratories for polio, measles, yellow fever, rubella, HPV, and meningitis

14) Formalize the institutional framework for AEFI management

- Train the service providers in AEFI surveillance in the 516 HZ

15) Coordination and Advocacy:

- Organize advocacy efforts targeted at the governments and the provincial assemblies of: Equator, Kinshasa, Katanga, North Kivu and South Kivu;

16) Mobilization of adequate resources:

- Organize two advocacy meetings to increase the health budget allocated to immunization at the central level

5.6. 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 sources of funding for Injection Safety equipment in 2014

Vaccine	Types of syringes used in the 2014 routine EPI	Funding sources in 2014
FR BCG	AD syringes BCG 0.05 ML	Government
FR Measles	AD syringe 0.5 ml	Government and GAVI
FR TT	AD syringe 0.5 ml	Government and GAVI
FR DTP-containing vaccine	AD syringe 0.5 ml	Government and GAVI
IPV		
Yellow Fever vaccine	0.5 ml self blocking syringe	Government and GAVI
PCV-13	0.5 ml self blocking syringe	Government and GAVI

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

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

IF NO: When will the country develop the injection safety policy? (Please report in the box below)

Yes, implementation of this plan is partial and there were problems after a default in funding.

Please explain how sharps have been eliminated in 2014, what were the problems faced, etc.

In the year 2014, waste is still collected in safety boxes and are eliminated by burning and then burying, in all immunization facilities. However, some facilities have improved ovens and very few use incinerators.

6. Immunization Services Support (ISS)

6.1. Report on the use of ISS funds in 2014

Democratic Republic of Congo (Kinshasa) is not reporting on the use of Immunization Services Support (ISS) funds in 2014

6.2. Detailed expenditure of ISS funds during the calendar year

Democratic Republic of Congo (Kinshasa) is not reporting on the use of Immunization Services Support (ISS) funds in 2014

6.3. ISS Funding Application

The request for expected ISS reward is not applicable for 2014 in the Democratic Republic of Congo (Kinshasa)

7. Support for New and Under-used Vaccines (NVS)

7.1. Receipt of new & under-used vaccines for the 2014 immunization program

7.1.1. Did you receive the approved amount of vaccine doses for the immunization program in 2014 that GAVI specified in their Decision Letter? Please fill the table below

Table 7.1: Vaccines actually received in 2014 compared to the quantity approved for 2014

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

	[A]	[B]	[C]	
Vaccine Type	**Total doses for 2014 in the Decision Letter**	**The number of total doses received by December 31, 2014**	**Total doses postponed from previous years and received in 2014**	**Has the country experienced a stock-out at any level in 2014?**
Pneumococcal (PCV13)	10,731,600	6,976,800	0	Yes
DTP-HepB-Hib	9,202,500	7,178,500	0	No
Yellow fever	5,086,300	4,958,000	0	Yes
IPV		0	0	Not selected

If numbers [A] and [B] are different, specify:

- What were the main problems encountered? (Was the lower than anticipated vaccine utilization due to a delay in the introduction of a new vaccine or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with the cold chain? Doses discarded because the VVM changed color or because of the expiry date?)

With regard to vaccine management, the country saw an irregular supply which caused several stock-outs at the central level for MV (10 days), YFV (69 days), and BCG (48 days), as well as in the inoculation material such as AD syringes BCG (48 days), SD 2 ml (125 days) and AD syringes 0.5 ml (37 days). These stock-outs reverberated to different immunization points in the provinces. This explains the discrepancies observed between the coverage of MV and that of YFV.

For PCV-13, the quantities supplied were always lesser than the requirement which caused several stock-outs at the intermediate and operational levels. This also explains the poor vaccination coverage for PCV-13 as compared to DTP-HepB-Hib and OPV

- What actions have you taken to improve vaccine management, e.g. such as amending the schedule for vaccine deliveries? (within the country and with the UNICEF Supply Division)

GAVI would also appreciate feedback from countries on the feasibility and interest of selecting and being sent multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to reduce wastage and cost to a minimum, and maximize coverage.

No steps were taken for 2014, but an adjustment in planning was made in terms of quantity for the year 2015.
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After an analysis of requirements for 2015, it was maintained that all requirements stated for 2015 will be met only when quantities of to the order of 1,782,000 doses are added for co-financing of PENTAVALENT in 2014 and 2,865,600 doses are added to the 2013 co-financing for PCV-13;

The meeting between the Country and GAVI is planned for this year, 2015, to take these adjustments into account.

If **Yes** marked for any vaccine in **Table 7.1,** indicate the duration, reason, and impact of stock-out including stock-out at central, regional, district or a lower level.

With regard to vaccine management, the country saw an irregular supply which caused several stock-outs at the central level for MV (10 days), YFV (69 days), and BCG (48 days), as well as in the inoculation material such as AD syringes BCG (48 days), SD 2 ml (125 days) and AD syringes 0.5 ml (37 days). These stock-outs reverberated to different immunization points in the provinces. This explains the discrepancies observed between the coverage of MV and that of YFV.

For PCV-13, the quantities supplied were always lesser than the requirement which caused several stock-outs at the intermediate and operational levels. This also explains the poor vaccination coverage for PCV-13 as compared to DTP-HepB-Hib and OPV

The other impact was the increase in the frequency of supply which created an additional cost at each level of the supply chain

7.2. Introduction of a New Vaccine in 2014

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2014, please refer to the vaccine introduction plan in the proposal approved and report on progress:

Yellow fever, 10 dose(s) per vial, LYOPHILIZED		
Nationwide introduction	No	
Phased introduction	No	
Was the time and scale of the introduction as planned in the proposal? If No, Why?	No	The vaccine was introduced from 2003

Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
Was the time and scale of the introduction as planned in the proposal? If No, Why?	Yes	The vaccine was gradually introduced from 2011 to 2013

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
Was the time and scale of the introduction as planned in the proposal? If No, Why?	Yes	The vaccine was introduced from 2009

IPV, 10 dose(s) per vial, LIQUID		
Nationwide introduction	No	
Phased introduction	No	
Was the time and scale of the introduction as planned in the proposal? If No, Why?	Yes	The vaccine is expected to be introduced in phases from April to July 2015

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

The DRC started the process of new vaccine (PCV-13) introduction per group of provinces since April 2011 and closed it in September 2013. This process saw a huge delay after the default in co-financing and also after the delay in purchasing and installing new cold chain units for the entire country. The new vaccine introduction plan provided for conducting Post-Introduction Evaluations (PIE) in provinces where they were introduced, for the purpose of drawing lessons and proposing corrective measures to help improve the introduction process in other provinces. Which is why the DRC conducted internal PIEs in the provinces of Kinshasa, Bas Congo, Nord Kivu, and Sud Kivu. The weaknesses observed during the evaluations pushed the EPI and its partners to adopt a pre-introduction evaluation approach accompanied by advocacy efforts targeted at the politico-administrative authorities in the provinces preparing to introduce the new vaccine. The last 7 provinces (Bandundu, Western Kasaï, Eastern Kasaï, Maniema, Katanga, Equateur and Eastern Province) thus benefitted from the preparatory pre-introduction evaluations. An internal Post-Introduction Evaluation was conducted in October 2013 in the provinces of Western Kasai, Eastern Kasai, and Maniema for the purpose of verifying the effectiveness of the steps taken to improve the introduction process.

1.3. Summary of observations:

- Political involvement with good planning, staff training at all levels, and spreading good awareness among the communities for the introduction of PCV-13
- Overall acceptance of the PCV-13 vaccine (staff, communities, etc.)
- Availability of training modules, fact sheets, and publicity pamphlets
- Cascading system of training for staff at all levels and before introduction
- Poor availability of refrigerators at the operational level and weaknesses in vaccine management with several stock-outs of the PCV-13 vaccine at all levels
- Non-utilization of freeze indicators during transportation of vaccines from the central level to the provinces, branches, and Health zones
- Inadequate infrastructure to eliminate waste and for adequate implementation of the waste management policy
- Absence of notification and AEFI management at all levels
- Absence of some immunization support materials (cards, registers, etc.) updated with PCV-13 specifications in several structures
- Insufficient post-introduction supervisions at the provincial and operational levels
- Limited number of sentinel sites (2 at Kinshasa and 1 at Lubumbashi) compared to the country overall
- Poor coverage of health centers in terms of slow cold chain equipment (refrigerators)
- Archival of coverage data, vaccine management data, and training and supervision documents is very poor
- Funding and immunization carried out by the national level continue to face difficulties
- Advocacy efforts for immunization are targeted at the decision-makers

1.4. Main recommendations:

At the central level

- Make resources available for the purchase of vaccines within the required timeframe
- Develop and implement an AEFI management policy
- Set up resources for adequate waste management at the operational level (institute guidelines and set up infrastructure for elimination of waste, etc.)
- Increase the number of sentinel surveillance sites and provide support to laboratories to avoid stock-outs in reagents
- Ensure a certain frequency of supervision and adequate archival
- Set up adequate storage zones for dry inputs
- Make sufficient immunization support material updated with PCV-13 specifications (cards, registers, etc.) available
- Undertake advocacy efforts to purchase freeze indicators and refrigerators for the HC

At the intermediate level and the Central Offices of the Health zones

- Ensure that a plan/schedule is prepared for the introduction of every new vaccine
- Carry out an analysis to determine the causes for high temperatures in refrigerators, and for stock-outs, and implement appropriate solutions
- Ensure a certain frequency of supervision and adequate archival
- Implement an AEFI management policy which will be identified
- Ensure training of HC staff in practical EPI (immunization sessions, knowledge of diseases, etc.)

At the Health Centers

- Ensure adequate monitoring of refrigerator temperatures
- Continue to inform mothers about immunization
- Ensure proper archival of documents
- Implement guidelines on waste management particularly proper up-keep of elimination sites

Note: An implementation plan for recommendations resulting from this evaluation is proposed as annex to the evaluation report

7.2.3. Adverse Events Following Immunization (AEFI)

Is there a national system dedicated to vaccinal pharmacovigilence? **Yes**

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

Does the country have an institutional development plan for vaccine safety? **Yes**

Is the country sharing its vaccine safety data with other countries? **Yes**

Has your country implemented a risk communication strategy, along with national preparedness plans, to deal with possible immunization issues? **No**

7.2.4. Supervision

Has your country set up a sentinel monitoring system for:

a. Rotavirus diarrhea? **Yes**

b. Bacterial meningitis or pneumococcal or meningococcal disease in children? **Yes**

Has your country conducted special studies on:

a. Rotavirus diarrhea? **No**

b. Bacterial meningitis or pneumococcal or meningococcal disease in children? **No**

If yes, does the National Technical Advisory Group on Immunization (ITAG) or the Interagency Coordinating Committee (ICC) regularly examine the data from national sentinel surveillance systems and from special

studies to make recommendations on the quality of data produced and on how to further improve the quality of the data? **Yes**

Are you planning to use the data from national sentinel surveillance and special studies to monitor and assess the impact of the introduction and use of vaccines? **Yes**

Please describe the results of monitoring/special studies and NITAG/ICC contributions:

7.3. Lump sum allocation for the introduction of a new vaccine in 2014

7.3.1. Financial Management Report

	Amount in US$	Amount in local currency
Funds received in 2014 (A)	0	0
Balance of funds carried forward from 2013	0	0
Total Available Funds in 2014 (C=A+B)	0	0
Total expenditure in 2014(D)	0	0
Balance carried over to 2015 (E=C-D)	0	0

Detailed expenditure from the New Vaccines Introduction Grant funds during the calendar year 2014

Please attach a detailed financial statement for the use of ISS funds during the calendar year 2014 (Document No. 10, 11). The terms of reference for this financial statement are attached in **Annex 1.** Financial statements should be signed by the Finance Manager of the EPI Program and the EPI Manager, or by the Permanent Secretary of Ministry of Health.

7.3.2. Program Report

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.

Not applicable

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

Not applicable

Please describe the activities that will be undertaken with the balance of funds carried forward to 2015

Not applicable

7.4. Report on country co-financing in 2014

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2014?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Selected vaccine #1: Yellow fever, 10 dose(s) per vial, LYOPHILIZED	840,489	91,890
Selected vaccine #2: Pneumococcal (PCV13), 1 dose per vial, LIQUID	0	0
Selected vaccine #3: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0

Selected vaccine #4: IPV, 10 dose(s) per vial, LIQUID*	0	0
	Q.2: What were the shares of country co-financing during the reporting year 2014 from the following sources?	
Government	4,547,845	
Donor	66,059,562	
Others	0	
	Q.3: Did you procure related injection supplies for the co-financing vaccines? What were the amounts in US$ and in supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Selected vaccine #1: Yellow fever, 10 dose(s) per vial, LYOPHILIZED	0	0
Selected vaccine #2: Pneumococcal (PCV13), 1 dose per vial, LIQUID	0	0
Selected vaccine #3: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0
Selected vaccine #4: IPV, 10 dose(s) per vial, LIQUID*	0	0
	Q.4: When do you intend to transfer funds for co-financing in 2016 and what is the expected source of this funding?	
Schedule of Co-Financing Payments	Proposed Payment Date for 2016	Funding source
Selected vaccine #1: Yellow fever, 10 dose(s) per vial, LYOPHILIZED	December	Government
Selected vaccine #2: Pneumococcal (PCV13), 1 dose per vial, LIQUID	December	Government
Selected vaccine #3: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	December	Government
Selected vaccine #4: IPV, 10 dose(s) per vial, LIQUID*	December	Government
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilizing funding for immunization, including for co-financing.	
	The country needs technical assistance in the advocacy at the highest level: 1. The Heads (Vaccine purchase and co-financing) IN THE State budget become a binding expenditure for the Government 2. Funds disbursed for the purchase of Vaccines and Other inputs should be transferred from time to time to avoid stock-outs of vaccines and inputs at all levels. 3. The project on the Integrated Health Act also includes the immunization perspectives.	

***Note:** co-financing is not mandatory for the IPV

Is GAVI's support, in relation to new or under-used vaccines and supply of injections, reported in the national health sector budget? **Yes**

7.5. Vaccine Management (EVM/VMA/EVSM)

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. The information on the EVM tool can be found at
http://www.who.int/immunization/programmes_systems/supply_chain/evm/en/index3.html

It is mandatory for the countries to conduct a Vaccine Management Assessment (VMA) prior to an application for the introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines. The progress of the implementation of this plan is reported in the Annual Progress Report. The VMA is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **October 2014**

Please attach the following documents:

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

b) improvement plan after EVM **(Document No. 13)**

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

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

Have there been any changes in the Improvement plan, and why? **Non** If yes, give details

When is the next Effective Vaccine Management (EVM) assessment planned? **October 2017**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2014

Democratic Republic of Congo (Kinshasa) is not submitting a report on NVS as part of the prevention campaign

7.7. Change in vaccine presentation

Democratic Republic of Congo (Kinshasa) does not require changes in vaccine presentation in the coming years.

7.8. Renewal of multi-year vaccine support for those countries whose current support is ending in 2015

If 2015 is the last year of approved multi-year support for a vaccine and the country wishes to extend the GAVI support, the country must apply for an extension of the co-funding agreement with GAVI for vaccine support commencing from 2016 and for the duration of a new comprehensive multi-year plan (cMYP).

The country hereby requests an extension of GAVI support for the years 2015 to 2020 for the following vaccines:

* **Yellow fever, 10 dose(s) per vial, LYOPHILIZED**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**
* **IPV, 10 dose(s) per vial, LIQUID**

At the same time it commits itself to co-finance the procurement of the following vaccines in accordance with the minimum Gavi co-financing levels as summarised in section 7.11 Calculation of requirements.

* **Yellow fever, 10 dose(s) per vial, LYOPHILIZED**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**
* **IPV, 10 dose(s) per vial, LIQUID**

The multi-year support extension is in line with the new cMYP for the years 2015 to 2020, which is attached to this APR (Document N°**16**). The new costing tool is also attached (Document No. **17**) for the following vaccines:

* **Yellow fever, 10 dose(s) per vial, LYOPHILIZED**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**
* **IPV, 10 dose(s) per vial, LIQUID**

The country ICC has endorsed this request for extended support of the following vaccines at the ICC meeting whose minutes are attached to this APR. (Document No. **18**)

* **Yellow fever, 10 dose(s) per vial, LYOPHILIZED**
* **Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID**
* **DTP-HepB-Hib, 10 dose(s) per vial, LIQUID**
* **IPV, 10 dose(s) per vial, LIQUID**

7.9. Request for continued support for vaccines for 2016 immunization program

In order to request NVS for vaccination in 2016 do the following:

Confirm here below that your request for 2016 vaccines support is as per table 7.11 Calculation of requirements **Yes**

If you do not confirm, please explain:

As part of the project for demonstrating the introduction of HPV in 2 health zones

7.10. Weighted average prices of supply and related freight costs

Table 7.10.1: Commodities Cost

The estimated cost of supplies is not disclosed

Table 7.10.2: Freight cost

Vaccine Antigens	Vaccine Type	2007	2008	2009	2010	2011	2012	2013
Yellow fever, 10 dose(s) per vial, LYOPHILIZED	Yellow fever, 10 dose(s) per vial, LYOPHILIZED							
Pneumococcal (PCV13), 1 dose per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID							
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID							
IPV, 10 dose(s) per vial, LIQUID	IPV, 10 dose(s) per vial, LIQUID							

Vaccine Antigens	Vaccine Type	2014	2015	2016	2017	2018	2019	2020
Yellow fever, 10 dose(s) per vial, LYOPHILIZED	Yellow fever, 10 dose(s) per vial, LYOPHILIZED	7.50%	7.50%	7.40%	7.20%	6.80%	6.80%	6.30%
Pneumococcal (PCV13), 1 dose per vial, LIQUID	Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	4.40%	4.50%	3.00%	4.50%	4.60%	3.10%	3.10%
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	3.40%	4.30%	3.60%	4.40%	4.40%	4.40%	4.40%
IPV, 10 dose(s) per vial, LIQUID	IPV, 10 dose(s) per vial, LIQUID		7.70%	7.50%	8.60%	8.60%	9.90%	9.90%

7.11. Calculation of requirements

Table 7.11.1: Characteristics for DTP-HepB-Hib, 10 doses per vial, LIQUID

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	3,107,737	3,200,969	3,296,998	9,605,704
	Number of children to be vaccinated with the first dose	Parameter	#	2,921,273	3,040,920	3,066,208	9,028,401
	Number of children to be vaccinated with the third dose	Parameter	#	2,921,273	2,880,872	3,000,268	8,802,413
	Immunization coverage with the third dose	Parameter	%	94.00%	90.00%	91.00%	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.05	1.11	1.11	
	Stock in Central Store Dec 31, 2014		#	1,150,800			

	Stock across second level Dec 31, 2014 (if available)*		#	1,150,800			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		10	10	
	Number of AD syringes required	Parameter	#		Yes	Yes	
	Number of reconstitution syringes required	Parameter	#		No	No	
	Number of safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.20	0.20	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		4.30%	3.60%	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The opening stock on January 1, 2015 is 1,150,800 doses.
The Country did not record any difference between the stock on December 31, 2014 and that on January 1, 2015.

For Pentavalent vaccines, GAVI applies an indicator of 4.5 months of buffer stock + operational stock. The countries must indicate their needs in terms of buffer stock + operational stock, if they are different from the indicator for up to a maximum of 6 months. If you need help to calculate the levels of buffer and operational stocks, please contact the WHO or UNICEF. By default, the pre-selection provides a buffer stock+ operational stock for 4.5 months. **Not defined**

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

Co-financing group	Low

	2014	2015	2016
Minimum co-financing	0.20	0.20	0.20
Recommended co-financing as per			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	2016
Number of vaccine doses	#	8,304,000	8,249,500	12,454,100
Number of AD syringes	#	9,640,300	8,413,000	14,246,200
Number of reconstitution syringes	#	0	0	0
Number of safety boxes	#	107,025	92,550	153,500
Total value to be co-financed by GAVI	$	17,574,500	16,787,500	23,756,000

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

		2014	2015	2016
Number of vaccine doses	#	898,500	377,500	1,499,000
Number of AD syringes	#	0	0	0
Number of reconstitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value of country co-financing*[1]*	$	1,840,500	747,000	2,859,500

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

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-financing**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	2,921,273	3,040,920		
B 1	**Number of children to be vaccinated with the third dose**	*Table 4*	2,921,273	3,040,920		
C	**Number of doses per child**	*The immunization schedule*	3	3		
D	**Number of doses required**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	8,763,819	8,897,093		
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.11		
F	**Number of doses required taking wastage into account**	*D x E*		9,875,773		
G	**Buffer stock of vaccines**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0, 375* ***Buffer on doses wasted*** = • *<u>if(wastage factor of previous year current estimation < wastage factor of previous year original approved):</u> ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0, 375* • *<u>else:</u> (F - D - ((F - D) of previous year original approved)) x 0, 375 >= 0*				
H	**Stock to be deducted**	*H1 - (F (2015) current estimation x 0, 375)*				
H 1	**Initial stock calculated**	*H2 (2015) + H3 (2015) - F (2015)*				
H 2	**Stock on 1st January**	*Table 7.11.1*	936,886	1,150,800		
H 3	**Dispatch schedule**	*Approved volume*		8,627,000		
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*		8,627,000		
J	**Number of doses per vial**	*Vaccine parameter*				
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*				
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*				
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*				
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*				
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*				
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*				
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*				
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*				
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*				
T	**Total funds required**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

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

		Formula	2016		
			Total	Government	GAVI
A	Country co-financing	*V*	10.74%		
B	Number of children to be vaccinated with the first dose	*Table 4*	3,066,208	329,401	2,736,807
B 1	Number of children to be vaccinated with the third dose	*Table 4*	3,000,268	322,317	2,677,951
C	Number of doses per child	*The immunization schedule*	3		
D	Number of doses required	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	9,105,649	978,213	8,127,436
E	Estimated vaccine wastage factor	*Table 4*	1.11		
F	Number of doses required taking wastage into account	*D X E*	10,107,270	1,085,816	9,021,454
G	Buffer stock of vaccines	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0, 375* ***Buffer on doses wasted*** = • *if(wastage factor of previous year current estimation < wastage factor of previous year original approved): ((F - D) - ((F - D) of previous year original approved - (F - D) of previous year current estimation)) x 0, 375* • *else: (F - D - ((F - D) of previous year original approved)) x 0, 375 >= 0*	86,812	9,327	77,485
H	Stock to be deducted	*H1 - (F (2015) current estimation x 0, 375)*	- 3,758,572	- 403,780	- 3,354,792
H 1	Initial stock calculated	*H2 (2015) + H3 (2015) - F (2015)*	- 66,834	- 7,179	- 59,655
H 2	Stock on 1st January	*Table 7.11.1*			
H 3	Dispatch schedule	*Approved volume*			
I	Total vaccine doses required	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	13,953,000	1,498,959	12,454,041
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of Auto-disable syringes required (+10% wastage)	*(D + G – H) x 1.10*	14,246,137	0	14,246,137
L	Number of Reconstitution syringes required (+10% wastage)	*(I / J) x 1.10*	0	0	0
M	Total number of safety boxes required (10% extra)	*(I / 100) x 1.10*	153,483	0	153,483
N	Cost of the required vaccines	*I x price of vaccine per dose (g)*	25,073,541	2,693,630	22,379,911
O	Cost of the required AD syringes	*K x AD syringe price per unit (ca)*	638,227	0	638,227
P	Cost of the required reconstitution syringes	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	Cost of the safety boxes required	*M X unit price of safety boxes (cs)*	835	0	835
R	Freight cost of the required vaccines	*N x Freight cost as % of vaccine value (fv)*	902,648	96,971	805,677
S	Freight cost of the required material	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	Total funds required	*(N+O+P+Q+R+S)*	26,615,251	2,859,254	23,755,997
U	Total country co-financing	*I x Country co-financing per dose (cc)*	2,790,600		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	10.74%		

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.1: Characteristics for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	3,107,737	3,200,969	3,296,998	9,605,704
	Number of children to be vaccinated with the first dose	Parameter	#	2,828,041	3,040,920	3,066,208	8,935,169
	Number of children to be vaccinated with the third dose	Parameter	#	2,545,237	2,880,872	3,000,268	8,426,377
	Immunization coverage with the third dose	Parameter	%	81.90%	90.00%	91.00%	
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Parameter	#	1.05	1.05	1.05	
	Stock in Central Store Dec 31, 2014		#	250,600			
	Stock across second level Dec 31, 2014 (if available)*		#	250,600			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		1	1	
	Number of AD syringes required	Parameter	#		Yes	Yes	
	Number of reconstitution syringes required	Parameter	#		No	No	
	Number of safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.20	0.20	**cc**
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	**ca**
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	**cr**
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	**Cs**
fv	**Freight cost as % of vaccines value**	Parameter	%		4.50%	3.00%	

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The opening stock on January 1, 2015 is 250,600 doses.
The Country did not record any difference between the stock on December 31, 2014 and that on January 1, 2015.

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

Co-financing group	Low		
	2014	**2015**	**2016**
Minimum co-financing	0.20	0.20	0.20
Recommended co-financing as per			0.20
Your co-financing	0.20	0.20	0.20

Table 7.11.4: Calculation of requirements for Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID

(part 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-financing**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	2,828,041	3,040,920		
C	**Number of doses per child**	*The immunization schedule*	3	3		
D	**Number of doses required**	*B x C*	8,484,123	9,122,760		
E	**Estimated vaccine wastage factor**	*Table 4*	1.05	1.05		
F	**Number of doses required taking wastage into account**	*D x E*		9,578,898		
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*				
H	**Stock to be deducted**	*H2 of the previous year - 0.25 x F of the previous year*				
H 2	**Stock on 1st January**	*Table 7.11.1*	404,167	250,600		
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*		9,747,000		
J	**Number of doses per vial**	*Vaccine parameter*				
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*				
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*				
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*				
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*				
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*				
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*				
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*				
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*				
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*				
T	**Total funds required**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

Table 7.11.4: Calculation of requirements forPneumococcal (PCV13), 1 dose(s) per vial, LIQUID (part 2)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-financing**	*V*	5.75%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,066,208	176,253	2,889,955
C	**Number of doses per child**	*The immunization schedule*	3		
D	**Number of doses required**	*B x C*	9,198,624	528,757	8,669,867
E	**Estimated vaccine wastage factor**	*Table 4*	1.05		
F	**Number of doses required taking wastage into account**	*D x E*	9,658,556	555,195	9,103,361
G	**Buffer stock of vaccines**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	23,516	1,352	22,164
H	**Stock to be deducted**	*H2 of the previous year - 0.25 x F of the previous year*	0	0	0
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	9,682,200	556,554	9,125,646
J	**Number of doses per vial**	*Vaccine parameter*	1		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	10,144,354	0	10,144,354
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	106,505	0	106,505
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	32,706,472	1,880,039	30,826,433
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	454,468	0	454,468
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	580	0	580
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	981,195	56,402	924,793
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	34,142,715	1,962,598	32,180,117
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	1,936,440		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	5.75%		

Table 7.11.1: Characteristics for Yellow fever, 10 dose(s) per vial, LYOPHILIZED

ID		Source		2014	2015	2016	TOTAL
	Number of surviving infants	Parameter	#	3,107,737	3,200,969	3,296,998	9,605,704
	Number of children to be vaccinated with the first dose	Parameter	#	2,796,963	2,880,872	2,967,298	8,645,133
	Number of doses per child	Parameter	#	1	1	1	

	Estimated vaccine wastage factor	Parameter	#	1.67	1.18	1.25	
	Stock in Central Store Dec 31, 2014		#	1,693,900			

	Stock across second level Dec 31, 2014 (if available)*		#	1,693,900			
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#				
	Number of doses per vial	Parameter	#		10	10	
	Number of AD syringes required	Parameter	#		Yes	Yes	
	Number of reconstitution syringes required	Parameter	#		Yes	Yes	
	Number of safety boxes required	Parameter	#		Yes	Yes	
cc	**Country co-financing per dose**	Parameter	$		0.20	0.20	
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	
fv	**Freight cost as % of vaccines value**	Parameter	%		7.50%	7.40%	
fd	**Freight cost as % of material value**	Parameter	%				

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

Co-financing group	Low

The opening stock on January 1, 2015 is 1,693,900 doses.

	2014	**2015**	**2016**
Minimum co-financing	0.20	0.20	0.20
Recommended co-financing as per			0.20
Your co-financing	0.20	0.20	0.20

The Country did not record any difference between the stock on December 31, 2014 and that on January 1, 2015.

Co-financing table for Yellow fever, 10 dose(s) per vial, LYOPHILIZED

Table 7.11.4: Calculation of requirements for Yellow fever, 10 dose(s) per vial, LYOPHILIZED (section 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-financing**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	2,796,963	2,880,872		
C	**Number of doses per child**	*The immunization schedule*	1	1		
D	**Number of doses required**	*B x C*	2,796,963	2,880,872		
E	**Estimated vaccine wastage factor**	*Table 4*	1.67	1.18		
F	**Number of doses required taking wastage into account**	*D x E*		3,399,429		
G	**Buffer stock of vaccines**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*				
H	**Stock to be deducted**	*H2 of the previous year - 0.25 x F of the previous year*				
H 2	**Stock on 1st January**	*Table 7.11.1*	85,350	1,693,900		
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*		2,992,300		
J	**Number of doses per vial**	*Vaccine parameter*				
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*				
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*				
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*				
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*				
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*				
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*				

Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*				
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*				
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*				
T	**Total funds required**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

Table 7.11.4: Calculation of requirements for Yellow fever, 10 dose(s) per vial, LYOPHILIZED (section 2)

		Formula	2016		
			Total	Government	GAVI
A	**Country co-financing**	*V*	18.77%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	2,967,298	557,026	2,410,272
C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	2,967,298	557,026	2,410,272
E	**Estimated vaccine wastage factor**	*Table 4*	1.25		
F	**Number of doses required taking wastage into account**	*D x E*	3,709,123	696,282	3,012,841
G	**Buffer stock of vaccines**	***Buffer on doses needed*** + ***buffer on doses wasted*** ***Buffer on doses needed*** = *(D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** = *(F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	27,009	5,071	21,938
H	**Stock to be deducted**	*H2 of the previous year - 0.25 x F of the previous year*	844,043	158,445	685,598
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	2,892,100	542,910	2,349,190
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	2,365,291	0	2,365,291
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	318,131	0	318,131
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	31,814	0	31,814
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	2,868,964	538,566	2,330,398
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	105,966	0	105,966
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	11,135	0	11,135
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	174	0	174

R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	212,304	39,855	172,449
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	3,198,543	600,436	2,598,107
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	578,420		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	18.77%		

Table 7.11.1: Characteristics for IPV, 10 doses per vial, LIQUID

ID		Source		2014	2015	2016	2017	2018
	Number of surviving infants	Parameter	#	3,107,737	3,200,969	3,296,998	3,395,908	3,497,785
	Number of children to be vaccinated	Parameter	#	0	2,005,181	3,316,998	3,395,908	3,497,785
	Number of doses per child	Parameter	#	1	1	1	1	1

	Estimated vaccine wastage factor	Parameter	#	1.00	2.00	1.82	1.67	1.54
	Stock in Central Store Dec 31, 2014		#	0				

	Stock across second level Dec 31, 2014 (if available)*		#	0				
	Stock across third level Dec 31, 2014 (if available)*	Parameter	#					
	Number of doses per vial	Parameter	#		10	10	10	10
	Number of AD syringes required	Parameter	#		Yes	Yes	Yes	Yes
	Number of reconstitution syringes required	Parameter	#		No	No	No	No
	Number of safety boxes required	Parameter	#		Yes	Yes	Yes	Yes
cc	**Country co-financing per dose**	Parameter	$		0.00	0.00	0.00	0.00
ca	**AD syringe price per unit**	Parameter	$		0.0448	0.0448	0.0448	0.0448
cr	**Reconstitution syringe price per unit**	Parameter	$		0	0	0	0
cs	**Safety box price per unit**	Parameter	$		0.0054	0.0054	0.0054	0.0054
fv	**Freight cost as % of vaccines value**	Parameter	%		7.70%	7.50%	8.60%	8.60%

* Please describe the method used for stock count in the text box below. We assume the closing stock (Dec 31, 2014) is the same as the opening stock (Jan 1, {1}). If there is a difference, please provide details in the text box below.

The opening stock on January 1, 2015 is 0 doses because the Country has not yet introduced the vaccine and awaits its 1st stock from this month

Co-financing tables for IPV, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2014	**2015**	**2016**	**2017**	**2018**
Minimum co-financing			0.00	0.00	0.00
Recommended co-financing as per			0.00	0.00	0.00
Your co-financing		0.00	0.00	0.00	0.00

	2019	**2020**
Minimum co-financing	0.00	0.00
Recommended co-financing as per	0.00	0.00
Your co-financing	0.00	0.00

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2014	2015		
				Total	Government	GAVI
A	**Country co-financing**	*V*				
B	**Number of children to be vaccinated with the first dose**	*Table 4*	2,005,181	2,005,181		
C	**Number of doses per child**	*The immunization schedule*	1	1		
D	**Number of doses required**	*B x C*	0	2,005,182		
E	**Estimated vaccine wastage factor**	*Table 4*	1.00	2.00		
F	**Number of doses required taking wastage into account**	*D x E*		4,010,363		
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*				
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*				
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*				
H 2	**Stock on 1st January**	*Table 7.11.1*	0	0		
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*		4,177,500		
J	**Number of doses per vial**	*Vaccine parameter*				
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*				
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*				
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*				
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*				
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*				
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*				
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*				
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*				

S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*				
T	**Total funds required**	*(N+O+P+Q+R+S)*				
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*				
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*				

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2016		
			Total	**Government**	**GAVI**
A	**Country co-financing**	*V*	0.00%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,316,998	0	3,316,998
C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	3,316,998	0	3,316,998
E	**Estimated vaccine wastage factor**	*Table 4*	1.82		
F	**Number of doses required taking wastage into account**	*D x E*	6,036,937	0	6,036,937
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	207,697	0	207,697
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*	- 3,733,672	0	- 3,733,672
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*	- 2,224,438	0	- 2,224,438
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	9,979,200	0	9,979,200
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	7,984,204	0	7,984,204
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	109,772	0	109,772
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	13,272,336	0	13,272,336

O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	357,693	0	357,693
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	598	0	598
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	995,426	0	995,426
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	14,626,053	0	14,626,053
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00%		

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2017		
			Total	**Government**	**GAVI**
A	**Country co-financing**	*V*	0.00%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,395,908	0	3,395,908
C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	3,395,908	0	3,395,908
E	**Estimated vaccine wastage factor**	*Table 4*	1.67		
F	**Number of doses required taking wastage into account**	*D x E*	5,671,167	0	5,671,167
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	220,672	0	220,672
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*			
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*			
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	5,893,200	0	5,893,200
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	3,978,239	0	3,978,239

L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	64,826	0	64,826
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	6,847,899	0	6,847,899
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	178,226	0	178,226
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	353	0	353
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	588,920	0	588,920
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	7,615,398	0	7,615,398
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00%		

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 4)

		Formula	**2018**		
			Total	**Government**	**GAVI**
A	**Country co-financing**	*V*	0.00%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,497,785	0	3,497,785
C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	3,497,785	0	3,497,785
E	**Estimated vaccine wastage factor**	*Table 4*	1.54		
F	**Number of doses required taking wastage into account**	*D x E*	5,386,589	0	5,386,589
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	777,833	0	777,833
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*			
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*			

H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	6,165,000	0	6,165,000
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	4,703,180	0	4,703,180
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	67,815	0	67,815
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	7,151,400	0	7,151,400
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	210,703	0	210,703
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	369	0	369
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	615,021	0	615,021
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	7,977,493	0	7,977,493
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00%		

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 5)

		Formula	2019		
			Total	**Government**	**GAVI**
A	**Country co-financing**	*V*	0.00%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,602,719	0	3,602,719
C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	3,602,719	0	3,602,719
E	**Estimated vaccine wastage factor**	*Table 4*	1.43		
F	**Number of doses required taking wastage into account**	*D x E*	5,151,889	0	5,151,889

G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	815,772	0	815,772
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*			
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*			
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	5,968,800	0	5,968,800
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	4,860,341	0	4,860,341
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	65,657	0	65,657
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	6,010,582	0	6,010,582
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	217,744	0	217,744
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	358	0	358
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	595,048	0	595,048
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	6,823,732	0	6,823,732
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00%		

As the delivery schedule for 2014 is not yet available, the volume approved for 2014 is used as the best estimate of the delivery schedule in 2014. The information will be updated when the delivery schedule is available.

Table 7.11.4: Calculation of requirements for IPV, 10 dose(s) per vial, LIQUID (part 6)

		Formula	2020		
			Total	**Government**	**GAVI**
A	**Country co-financing**	*V*	0.00%		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	3,710,800	0	3,710,800

C	**Number of doses per child**	*The immunization schedule*	1		
D	**Number of doses required**	*B x C*	3,710,800	0	3,710,800
E	**Estimated vaccine wastage factor**	*Table 4*	1.43		
F	**Number of doses required taking wastage into account**	*D x E*	5,306,444	0	5,306,444
G	**Buffer stock of vaccines**	***Buffer on doses needed*** *+* ***buffer on doses wasted*** ***Buffer on doses needed*** *= (D - D of previous year original approved) x 0,25* ***Buffer on doses wasted*** *= (F - D) x [XXX] - ((F - D) of previous year current estimate) x 0,25*	939,319	0	939,319
H	**Stock to be deducted**	*H1 - 0.25 x F of previous year original approved*			
H 1	**Initial stock calculated**	*H2 of previous year + I of previous year - F of previous year current estimation*			
H 2	**Stock on 1st January**	*Table 7.11.1*			
I	**Total vaccine doses required**	*Rounding ((F + G - H) / vaccine pack size) x vaccine pack size*	6,246,000	0	6,246,000
J	**Number of doses per vial**	*Vaccine parameter*	10		
K	**Number of Auto-disable syringes required (+10% wastage)**	*(D + G – H) x 1.10*	5,115,131	0	5,115,131
L	**Number of Reconstitution syringes required (+10% wastage)**	*(I / J) x 1.10*	0	0	0
M	**Total number of safety boxes required (10% extra)**	*(I / 100) x 1.10*	68,706	0	68,706
N	**Cost of the required vaccines**	*I x price of vaccine per dose (g)*	6,289,722	0	6,289,722
O	**Cost of the required AD syringes**	*K x AD syringe price per unit (ca)*	229,158	0	229,158
P	**Cost of the required reconstitution syringes**	*L X Reconstitution syringe price per unit (cr)*	0	0	0
Q	**Cost of the safety boxes required**	*M X unit price of safety boxes (cs)*	374	0	374
R	**Freight cost of the required vaccines**	*N x Freight cost as % of vaccine value (fv)*	622,683	0	622,683
S	**Freight cost of the required material**	*(O+P+Q) x Freight cost as % of the value of supplies (fd)*	0	0	0
T	**Total funds required**	*(N+O+P+Q+R+S)*	7,141,937	0	7,141,937
U	**Total country co-financing**	*I x Country co-financing per dose (cc)*	0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	0.00%		

As the shipment schedules for 2014 are not yet available, the volume approved for 2014 is used

8. 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 the period January to December 2014.** All countries are expected to report on: a. The progress made in 2014

b. The implementation of HSS from January to April 2015 (interim

report) c. plans for 2016

d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last three months of 2014, or experienced other delays that limited implementation in 2014, this section can be used as an inception report on start-up activities.

In order to better align the HSS report to national procedures, for countries where the 2014 fiscal year starts in January 2014 and ends in December 2014, HSS reports should be received by the GAVI Alliance before **May 15, 2015**. For other countries, the HSS reports should be received by the GAVI Alliance approximately six months after the end of country's fiscal year, e.g., if the country's fiscal year ends in March 2015, the HSS reports are expected by GAVI Alliance by September2015.

3. Please use your approved proposal 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 template, as necessary.

4. If you would like to modify the objectives, activities and pre-approved budgets (reprogramming), please ask the person in charge of your country's application at the GAVI Secretariat for guidelines on reprogramming or send an email to gavihss@gavi.org.

5. If you are requesting additional funds, please make this clear in section 8.1.2.

6. Please ensure 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. Please attach all required supporting documents. These include:

a. Minutes of the HSCC meetings held in 2014

b. Minutes of the HSCC meeting in 2015 that endorsed this report

c. Latest Health Sector Review Report

d. Financial statement for the use of HSS funds in the calendar year 2014

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 installments of HSS funding:

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

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

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

8. Inaccurate, incomplete or unsubstantiated reports may lead the IRC to either send the APR back to your country for clarification (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 installment of HSS funding.

8.1. Report on the use of HSS funds in 2014 and request for additional funding

Countries that have already received the final disbursement of GAVI approved funds under HSS grant and require no further financing: Is the implementation of the HSS grant completed? YES/NO If NO, please indicate the anticipated date for completion of the HSS grant. **No**

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

HSS1 is expected to end on June 30, 2015.

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

Please attach the gender disaggregated data, if any, by rural/urban areas, district/state, especially for immunization coverage indicators. This is mainly important if the GAVI HSS grants are used to target populations and/or specific geographic locations in the country.

If the CSOs are involved in HSS implementation, please attach a list of those involved in implementing the grant, financing received by the CSOs for GAVI HSS grant and activities that are conducted. If the CSO involvement was already planned in the initial proposal approved by GAVI, but no financing was provided to CSOs, please explain why. Go to http://www.gavialliance.org/support/cso/, for the GAVI CSO implementation framework.

Yes, the Civil Society Organizations (CSO) were involved in round1 of Health System Strengthening (HSS1). The names of the CSOs are: National Council of NGOs for Health and the Congolese Red Cross are involved in the implementation of the HSS1 grant. The activities conducted most often were:

1. Strengthen the capacity of community members (RECO) in raising awareness for EPI and in the recovery of children left out of immunization, according to the immunization schedule.
2. Monitor steps taken in the 65 target HZ.
3. Educate the population about immunization.
4. Recovery of children left out of immunization, according to the WHO schedule
5. Monitor and evaluate field activities.

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

Please provide data sources for all data used in this report

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

8.1.1. Report on the use of HSS funds in **2014**

Please complete Table 8.1.3.a and 8.1.3.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 8.1.3.a and 8.1.3.b..

8.1.2. Please indicate if you are requesting additional funding **Yes**

If yes, please indicate the amount of funding requested: US$ **48,483,021**

These funds will be sufficient to ensure the HSS allocation till December 2016.

Table 8.1.3a $(US)

	2009	2010	2011	2012	2013	2014
Original annual budget (as in the *initially approved HSS proposal*)	11,909,538	7,660,518				
Revised annual budget (*if revised during a review of the previous years' annual reports*)	20,139,390	15,149,548				
Total funds received from GAVI during the calendar year *(A)*	0	0	0	0	15,148,955	2,329,974
Balance funds (carry over) from previous year (*A*)	41,556,480	35,715,187	17,248,126	16,896,284	10,109,536	21,061,830
Total Funds available during the calendar year *(C=A+B)*	41,556,480	35,715,187	17,248,126	16,896,284	25,260,536	23,870,451
Total expenditure during the calendar year (*D*)	5,841,293	18,469,961	381,842	6,786,748	5,698,705	13,331,213
Balance carried forward to the next calendar year *(E=C-D)*	35,715,187	17,248,126	16,896,284	10,109,536	19,561,830	10,539,238
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	0	0	0	0	15,148,955	2,329,974

	2015	2016	2017	2018
Original annual budget (as in the *initially approved HSS proposal*)				
Revised annual budget (*if revised during a review of the previous years' annual reports*)				
Total funds received from GAVI during the calendar year *(A)*				
Balance funds (carry over) from previous year (*A*)	10,539,238			

Total Funds available during the calendar year *(C=A+B)*	10,539,238			
Total expenditure during the calendar year (*D*)				
Balance carried forward to the next calendar year *(E=C-D)*				
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	48,483,021	36,087,793	26,732,125	16,893,866

Table 8.1.3b (Local currency)

	2009	2010	2011	2012	2013	2014
Original annual budgets (*as per the originally approved HSS proposal*)						
Revised annual budget (*if revised during a review of the previous years' annual reports*)						
Total funds received from GAVI during the calendar year (A)						
Remaining funds (carry over) from previous year (A)						
Total Funds available during the calendar year (C=A+B)						
Total expenditure during the calendar year (D)						
Balance carried forward to the next calendar year (E=C-D)						
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	0	0	0	0	0	0

	2015	2016	2017	2018
Original annual budget (as in the *initially approved HSS proposal*)				

Revised annual budget (*if revised during a review of the previous years' annual reports*)				
Total funds received from GAVI during the calendar year *(A)*				
Balance funds (carry over) from previous year (*A*)				
Total Funds available during the calendar year *(C=A+B)*				
Total expenditure during the calendar year (*D*)				
Balance carried forward to the next calendar year *(E=C-D)*				
Amount of funding requested for future calendar year(s) [please ensure that you complete this row if you are requesting additional funds]	0	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in Table 8.3.c below the exchange rate used for each calendar year at opening and closing.

Table 8.1.3.c

Exchange Rate	2009	2010	2011	2012	2013	2014
Opening on 1st January	680.77	909.89	920.15	917.79	915.95	926.63
Closing on 31st December	904.53	911.73	911.73	914.92	926.63	926

Detailed expenditure of HSS funds during the 2014 calendar year

Please attach a detailed financial statement on the use of HSS funds during the 2014 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 the Ministry of Health. **(Document Number: 19)**

If any expenditures for the January - April 2015 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)**

Has an external audit been carried out? Yes

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

8.2. Progress of the HSS activities in the 2014 fiscal year

Please report on any major measures taken to improve the immunization activities using HSS funds in Table 8.2. It is very important to be precise about the extent of progress made and the use of M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of the activity completed, where applicable
- A description of the progress made and any problems encountered
- The source of information and data, if relevant

Table 8.2: HSS activities in the reporting year 2014

Main Activities (insert as many rows as required)	**Activities planned for 2014**	**Percentage of activity completed (annual rate)** (where applicable)	**Source of information/data** (if relevant)
Activity 1.1	Provide support to the functioning of the National Steering Committee	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.2	Develop standards for the central and the intermediate levels	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.3	Develop standards for the central level (CL)	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.4	Provide support to the support missions of the CL in preparing operational Action plans in provinces	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.5	Monitor the implementation of Action plans for the supported provinces	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.9	Ensure the functioning of the HRH observatory and the Healthcare System set up in the health sector	50	Technical and Financial report of Central AGEFIN and CAGF 2014 and the D1
Activity 1.10	Ensure the functioning of the internet connection at the central level of the HS	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the EPI
Activity 1.11	Provide support to the organizing HSTCC meetings every quarter	62	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.12	Provide support to organizing the National Review of the Sector	0	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.8	Organize the big meeting of the National Steering Committee chaired by the Minister of Public Health	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.6	Participate in international conferences like the WHO World Assembly in Geneva	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.7	Organize monthly meetings of the NSC commissions	60	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.13	Short-term technical assistance and internal audit	74	Technical and Financial report of Central AGEFIN and CAGF 2014
Activity 1.14	Training and contracting, procurement, TOMPRO	0	Technical and Financial report of Central AGEFIN and CAGF 2014

Activity 1.15	International course in planning, provide support in this training for the MPH staff	0	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.16	Provide support to EPI functioning at the central level	81	Technical and Financial report of Central AGEFIN and MSU 2014 and the EPI

Activity 1.17	HSS1 evaluation	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.18	Joint monitoring mission at target HZ with the members of the HSTCC	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 1.19	Provide external audit support for the fiscal years 2013 and 2014	30	Technical and Financial report of Central AGEFIN and CAGF 2014
Activity 2.1	Provide support in preparing operational Action plans for 3 target PHD	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report of the provinces
Activity 2.2	Supervision of the HZ by teams of the Health Districts (4 missions/year)	35	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report of the provinces
Activity 2.3	Supervision of the target HZ by 3 target PHD (4 missions/year)	40	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report of the provinces
Activity 2.4	Restore 2 PRCs, Kindu and Lodja	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report of the provinces
Activity 2.5	Provide support to planning in provinces through experts of the CL	51	Technical and Financial report of Central AGEFIN and CAGF 2014 and the DSP
Activity 2.6	Provide support to the functioning of 3 target PHD (Kinshasa, Bas Congo, and South Kivu)	0	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 2.7	Provide support to organizing monthly meetings of the CPP commissions	77	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 2.8	Provide support to organizing bi-monthly meetings of the Technical Secretariat in target provinces	0	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 2.9	Provide support to the annual CPP review and to performance monitoring in the 65 HZ	14	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 2.10	Provide support to the functioning of 20 target Health Districts	0	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 2.11	Provide support to the functioning of 44 EPI branches	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces

Activity 2.12	Provide support to the functioning of 11 EPI provincial coordinations	11	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.1	Provide support in preparing operational plans of 65 target HZ	91	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.2	Restore/construct the HCs	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.3	Provide support to the functioning of 65 HGR and 65 HZ offices	59	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.4	Provide support to the HZ with speedboats	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.5	Provide water to the HC	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.6	Monitoring missions of the HZ for MEG credit lines of the HZ	100	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.7	Supervision of HC by the executive teams of the HZ	64	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.8	Provide support to vaccination activities in the HZ (REZ approach)	32	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 3.9	Provide support in creating awareness about immunization in the population through the members of the Civil Society Organizations	100	Technical and Financial report of Central AGEFIN and CAGF 2014, Annual Report 2014 of the provinces, and Annual Report of the CSO
Activity 3.10	Provide support to building of capacities of the community members through CSO in	100	Technical and Financial report of Central AGEFIN and CAGF 2014, Annual Report 2014 of the provinces, and Annual Report of the CSO
Activity 3.11	Creating awareness about routine EPI and recovery of children not reached by immunization	100	Technical and Financial report of Central AGEFIN and CAGF 2014, Annual Report 2014 of the provinces, and Annual Report of the CSO
Activity 3.12	Provide support to monitoring meetings for actions in HZ	100	Technical and Financial report of Central AGEFIN and CAGF 2014, Annual Report 2014 of the provinces, and Annual Report of the CSO
Activity 3.13	Organize monitoring missions in HZ through the CSO Steering Committee	100	Technical and Financial report of Central AGEFIN and CAGF 2014, Annual Report 2014 of the provinces, and Annual Report of the CSO

Activity 4.1	Training/retraining the Head nurses of the HC in their respective PHC hospitals	90	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces
Activity 4.2	Pay service provider bonus to HZ, HD, PHD, and CL	35	Technical and Financial report of Central AGEFIN and CAGF 2014 and Annual Report 2014 of the provinces

8.2.1. For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), describe the progress achieved and obstacles faced (e.g. assessments, HSCC meetings).

Main Activities (insert as many rows as required)	**Explain progress achieved and constraints**
Provide support in steering the Health System at the C.L.	16/19 activities were conducted at an average implementation rate of 68%. Obstacles faced: (i) funds sometimes made available with delays by the Financial Management Agency or AGEFIN to the directorates and central programs, (ii) difficulties in the correct drafting of quality applications by the beneficiaries at the central level, (iii) lack of or inadequate communication between the parties, sometimes requirements are not expressed by the beneficiaries, and the long procurement process discourages the beneficiaries from expressing their requirements.
Provide support in steering the Health System in the Provinces	9/12 activities were conducted at an average implementation rate of 44%. Obstacles faced: (i) funds sometimes made available with delays by the Central Financial Management Agency to the Provincial Financial Management Agencies namely FDSS, AAP and AGEC, and from these agencies to the Provincial Health Divisions, Coordinations and Branches, and the EPI HZ, (ii) difficulties in the correct drafting of quality applications by the beneficiaries at the provincial level and the HZ, (iii) lack of or inadequate communication between the parties, (iv) interruption in sending funds to the provinces during a six-month period due to change in the Financial Management Agency.
Ensure development of 65 HZ according to the SHSS	13/13 activities were conducted at an average implementation rate of 87%. Obstacles faced: (i) interruption in sending funds to the provinces during the second half of 2014, due to the change in AGEFIN. From KPMG to GIZ, (ii) difficulties in the correct drafting of quality applications by the HC and central offices of the beneficiary HZ, (iii) lack of or inadequate communication between the HZ and Provincial AGEFINs, and the enormous distances between the provincial AGEFIN and the HZ ranging from 50 to 500 km, a long procurement process that takes 3 to 6 months for acquisition, restoration, and the purchases for the HZ including replenishing vaccines, medicines, fuel, lubricants, and maintenance of vehicles.
Ensure development of Human Resources for Health	2/2 activities were conducted at an average implementation rate of 62.5%. Obstacles faced: The vastness of the country DRC for timely assessment of all beneficiaries for the quarterly performance bonus, and the lack of or inadequate communication between the beneficiaries and the provincial Financial Management Agencies.

8.2.2. Explain why certain activities have not been implemented, or have been modified, and give references.

DRC, since 2013 and 2014, has picked up momentum in its drastic health system reforms. In fact, the orders of the Minister of Public Health and the Minister for Public Service shook the organizational structure of the sector. For local support in Health zones, given the vastness of the country, it was decided in accordance with the order of the MPH to change from 11 provincial health divisions to 26 divisions. Therefore, among the activities which were not conducted, the following are mentioned: (i) the national annual review was not organized per se but was transformed into organizing a briefing of the 26 new Heads of Provincial Health Divisions (PHD) recruited by call for applicants and into holding a National Steering Committee or NSC meeting, (ii) support to the functioning of PHD and Health districts given the implementation of the new organizational structure which calls for 26 PHD in place of 11 PHD and the elimination of Health districts, (iii) the process of changing the Financial Management Agency was long and did not allow funding of the HZ activities in accordance with the Operational Action Plans (OAP) of the beneficiary facilities. Other activities not conducted with a 100% rate was due to this last reason among other reasons.

8.2.3. If the GAVI HSS grant has been utilized to provide incentives to national health human resources, how have these GAVI HSS funds been used to implement the National Policy or guidelines on Human Resource?

The Ministry of Health of DRC with its technical and financial partners particularly established during the high forums, the Kinshasa agenda, the complementarity strategy, and the alignment of activities in the sector. This is how, apart from the government salaries, the partners in the sector, including GAVI, give performance bonuses to the staff and workers of the beneficiary structures particularly in the PHD and HZ. Complementarity bonuses given to human resources in the health sector at all levels of our heath pyramid helped in: a significant improvement in the geographical coverage in terms of health staff, especially in rural areas, (ii) improvement in the quality of services and stability in the human resources at the national level. These funds, in synergy with the funds from other partners particularly the Japanese Cooperation and the WHO, also helped develop the National Human Resources Development Plan for health as well as in the functioning of the Human Resources for Health observatory in the health sector. However, this payment was suspended after the long recruitment process of another Financial Management Agency; a lot of the health personnel in the PHD and HZ could not give their best - same as earlier.

8.3. General overview of objectives achieved

Please complete **Table 8.3** for each indicator and objective outlined in the originally approved proposal and Decision Letter. Please use the baseline values and targets for 2013 from your original HSS proposal.

Table 8.3: Progress on targets achieved

Name of objective or indicator (Insert as many rows as required)	Baseline		Agreed target till end of support in original HSS application	2014 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2010	2011	2012	2013	2014		
Proportion of provinces with functional CPP	0%	DSP in 2005 (Annual Report)	100%	100%	54%	81%	100%	100%	100%	Annual Report of provinces in 2014	
Health coverage rate in 65 HZ	20%	DSP in 2005 (Annual Report)	80%	80%	50%	75%	85%	88%	90%	Annual Report of provinces in 2014	
% of additional children vaccinated with DTP3 in 65 HZ	0%	EPI in 2006 (Annual Report)	20%	20%	0%	0%	15%	20%	25%	Annual CSO report 2014 and Annual Report of Provinces	
% of additional children vaccinated with MV in 65 HZ	0%	EPI in 2006 (Annual Report)	20%	20%	0%	0%	10%	20%	18%	Annual CSO report 2014 and Annual Report of Provinces	

MV VC in 515 HZ in DRC	77%	EPI in 2006 (Annual Report)	90%	90%	87%	84.9%	89%	88%	72%	Demographic and Health Survey 2013-2014	Vaccine stock-outs in the HZ due to cumbersome procurement procedures for transportation, cumbersome disbursement by AGEFIN, insufficient stock of vaccines and inputs following the poor co-financing payment by the DRC, instability of service providers, and inadequate means to implement the REZ approach.
DTP3 VC in 515 HZ in DRC	77.2%	EPI in 2006 (Annual Report)	90%	90%	90%	89.7%	90.9%	90%	61%	Demographic and Health Survey 2013-2014	Vaccine stock-outs in the HZ due to cumbersome procurement procedures for transportation, cumbersome disbursement by AGEFIN, insufficient stock of vaccines and inputs following the poor co-financing payment by the DRC, instability of service providers, and inadequate means to implement the REZ approach.
Mortality Rate for children less than 5 years of age/1,000 live births	2003	MICS2 survey in 2001	185	< 185	185	148	148	104	104	Demographic and Health Survey 2013-2014	
Number of provinces with functional basket funding	0	DSP in 2005 (Annual Report)	11	11	6	7	7	7	7	Annual Report of provinces	Process not yet finalized in other provinces
Existence of only one Steering Committee	0	DSP in 2005 (Annual Report)	1	1	1	1	1	1	1	Order of December 3, 2009, creating NSC and CPP	

Budget implementation rate allocated to the 65 HZ	40%	DSP in 2005 (Annual Report)	80%	80%	63.3%	4%	32%	83%	62%	Technical and financial report of AGEFIN and CAGF	In 2014, in the second half of the year, the funds were not granted to the HZ except for the funds for restoration of the HC through FDSS and UNOPS
Proportion of functional HZs among those targeted	0%	DSP in 2005 (Annual Report)	100%	100%	75%	100%	100%	100%	100%	Annual Report of provinces	

8.4. Program implementation in 2014

8.4.1. Please describe the major achievements in 2014, especially the impact on health service programs, and how the HSS funds have contributed to the immunization program

DRC, since 2013 and 2014, has picked up momentum in its drastic health system reforms based on the Health System Strengthening Strategy or HSSS which falls under the restructuring of the public service and decentralization. This is the reason behind the order of the Minister of Public Service in this regard, giving the new organizational structure of the Ministry of Health, on the basis of which the Minister of Public Health issued another order regarding the reorganization of the Provincial Health Divisions (PHD) in DRC, taking the number of PHD from 11 to 26. This was for the sole purpose of strengthening the local technical support for the HZ staff through multi-functional supervisors recruited through a call for applicants for the PHD. In addition, the Country also got involved in a process of evaluating the HSS1 and preparing a new project to be submitted to GAVI before May 15, 2014, which was brilliantly executed. EPI and its partners resolved at the same time to review the comprehensive multi-year plan in view of the results of the external review of the program as well as the surveys of 2013 and 2014 (DHS), to adopt in the current situation in DRC. To improve future results in terms of management and good governance, the sector also set out to review its manual of procedures and recruit a new Financial Management Agency. Thus, the major accomplishments in 2014, particularly the impacts on health service programs and strengthening of the immunization program in DRC are described below:
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Continuing the implementation of the funding reform in the health sector through operationalization of the Financial Management and Support Unit (CAGF) with another Coordinator of the Financial Management Support Unit ai (CAGF ai) named in June 2014 through the order of the Minister of Public Health (MPH), and the launch of the process of changing the Central Financial Management Agency (AGEFIN) called by a new name on the decision of the partners (GAVI and FM), and the elimination of the provincial AGEFINs and its branches.

1. Capacity-building for vaccine storage at the intermediate level, in 11 coordinations and 44 branches, by equipping them with 60 additional solar refrigerators.

4. Training of EPI staff at the intermediate level (Province) in MLM (EPI Program Management)

5. Organize an immunization campaign against measles in the provinces of Katanga, the two Kasaï, Bandundu, Kinshasa, and Bas Congo

6. Strengthening of the National Drug Supply System by continuing to open lines of credit for purchasing medicines for 65 HZ with GAVI-HSS support.

7. Continuing to implement the NPMD by developing operational Action plans at all levels of the System (CL, IL and HZ) under the supervision of experts from the central level.

8. Preparation of the 2015-2019 EPI Comprehensive the Multi-Year Plan or cMYP as well as the EPI monitoring and evaluation plan.

9. Development of a country-level strategy to accelerate achievement of the 3rd and 4th Millennium Development Goals.

10. Continuing to strengthen epidemic surveillance at all levels of the Health System with Zero wild polio virus case declared in DRC.

11. Rigorous response to the Ebola epidemic resulting in monitoring and ending the Ebola epidemic after more than 4 months of unremitting response with the help of the entire health staff under the efficient and dynamic leadership of the HE the Minister of Public Health, Dr. Félix Kabange Numbi M.

12. Continuing post-introduction supervision of PCV-13 in the provinces of the DRC.

13. Implementation of a customized approach for DRC in order to resolve immunization problems specific to DRC.

14. HSS1 evaluation and the successfully developed HSS2 accepted by GAVI for 2015-2019 for more than $ 144,991,152;The second project will help us purchase two boats to solve the problem of transporting vaccines and inputs through implementation of the end-to-end supply chain strategy integrating all the technical and financial partners of MPH.

15. Successful development of the proposal for the new polio vaccine that GAVI accepted for an amount of 2.3 million, with its introduction planned for April 2015. This helps us in better monitoring and continuation of our performance showing Zero polio case in DRC till it is fully eradicated.

16. Reviewing and developing the manual of procedures with the involvement of all TFP of the MPH, the manual of management procedures enforceable for all at the MPH.

17. Organizing the selection process of an external audit firm of international acclaim and organizing audits for the years 2013 and 2014.

18. Purchasing 15 vehicles for EPI that will serve in transporting inputs, monitoring and evaluating programs as well as providing supportive supervision.

8.4.2. Please describe any problems encountered and solutions found or proposed to improve future results from HSS funding.

Generally, the major problems faced were: (i) non-availability of HSS funds in the 65 HZ, 3 PHD, and 4 Directorates (2, 4, 5, and 7) and 1 Health program (EPI) as planned in their Operational action plans 2014, due to: suspension of disbursement of funds to facilities especially while awaiting the completion of the operations of the new Financial Management Agency that replaced the old AGEFIN given the absence of the desired performance, (ii) lack of and inadequate communication among the HZ, PHD, and provincial AGEFIN and (iii) the long procurement process that takes 3 to 6 months for various acquisitions, restoration, purchases for the HZ, branches, EPI coordination, PHD, Directorates of Health Programs, particularly for replenishing the stock of vaccines, medicines, fuel, lubricants, and maintenance of vehicles, and restoration.
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1. Regarding EPI in particular:

2.1. The flagship strategy, “reach every child in each Health Zone” or REZ, is not completely implemented in the HZ; other than the micro-planning, the other components (supportive supervision, monitoring actions, and strengthening links with communities and the mobile and fixed strategies) are implemented with difficulty:

a) Specific strategies to reach the children in remote areas were not established, particularly in HZs with armed conflicts and having no help;

Failure to institute a system to recover people who have been lost sight of by the Community volunteers in several Health Centers;

b) Rate of implementation of supportive supervision continues to be lower than 45%;

c) Less than 60% of Health Areas organize monthly meetings for monitoring action;

2.2. Low percentage of staff trained in EPI management at all the peripheral level

2.3. Resurgence of the measles epidemic in some provinces having organized immunization campaigns: South-Kivu for example.

2.4. Irregularity in the disbursal of funds for transportation of vaccines and inputs to the provinces (coordinations, EPI branches, and to the HZ) is a frequently recurring problem for EPI, having faced stock-outs of vaccines and inputs very frequently in 2013 and 2014.

Possible solutions to improve future performance of HSS funds:

1. **In general:**

1.1. By recruiting a new AGEFIN, "GIZ", with a performance contract to be evaluated every six months.

1.2. By strengthening the technical monitoring of project implementation, regularly organizing meetings of the Ad hoc Committee in accordance with the directions in the Aide-memoire signed in May 2011 between MPH and GAVI-Alliance,

1.3. By organizing joint missions in provinces, adhering to the performance reporting timeframe (45 days after the end of the quarter), adhering to the timeline for disbursing funds (every six months),

1.4. By reorganizing in accordance with the order of HE Mr. MPH, the procurement unit, apart from the CAGF

1.5. And, by encouraging a constructive partnership between all players in the health sector, building capacities in communication, in software management of tompro and tommonitoring, in financial management, and in drafting quality applications with the new AGEFIN

2. **In particular**, with regard to **the impact of the HSS vaccination coverage**, the implementation plan for HSS2 activities is proposed to help strengthen the implementation of the REZ approach at the operational level and strengthen the supply chain from end to end to solve the problems in transportation of vaccines and inputs.

These activities are:

(i) provide support to planning for bottle-necks in vaccination services as described in the HSS2, in the health areas with the help of community participation,

(ii) provide support to organizing vaccination sessions at least 2 times/week in each health area for each fixed strategy - advanced and mobile,

(iii) provide support to organizing a quarter-wise supportive supervision in each health area under EPI,

(iv) provide support in organizing monitoring of EPI data every month in the HZ by the management team of the HZ,

(v) provide support to the purchase of social mobilization services for immunization in the HZ by Civil Society Organizations through relevant performance contracts for recovery of children lost to sight and/or found in difficult-to-reach health areas, as well as pre-school check-up of children from 0 to 59 months.

(vi) provide support to building capacities of the Management and the EPI experts in vaccinology and in healthcare logistics including program management (through the MLM course for the operational level or the HZ).

(vii) sign contracts for providing service with official carriers and/or who have aircrafts to solve the problem of frequent transportation of vaccines and inputs.

(viii) provide support to National Directorate for the Expanded Program on Immunization in terms of developing norms and guidelines, preparing annual reports, conducting capacity-building trainings, participating in international symposiums, national and international consultations, performance bonuses, meetings of the Technical Coordination Committees, activities of the National Health Information System, transportation of vaccines to different provinces and purchase of materials and equipment to strengthen the cold chain at the central level, in the provinces, and at the peripheral level.

8.4.3. Please describe the exact arrangements made at the different levels for the monitoring and evaluation of GAVI funded HSS activities.

The main monitoring and evaluation provisions for each level are described in detail in the Monitoring and Evaluation Framework document of the 2011-2015 National Plan for Medical Development. These mainly include:

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1. Pour the central level:

Monthly meetings of the NSC commissions:

these are thematic meetings that deal with problems that would hinder the implementation of the Health System Strengthening Strategy or HSSS. There are six commissions among others: leadership and good governance, planning, management and rationalization of human resources for health, health sector funding, medicines and medicinal plants, infrastructure and equipment. Each commission is chaired by the Central Director; the members are the Management and Experts of the MPH; the relevant decisions are discussed and approved in the meetings of the Technical Coordination Committee chaired by the Secretary General of Health.

Quarterly TCC meetings:

Members include central directors, partners of the health sector, and related partners. These are meetings that approve all big decisions for strengthening the HS which are then brought to the TCC for adoption.

National meeting of the National Steering Committee:

Once a year, with the possibility of an extra-ordinary meeting. This meeting is under the patronage of His Excellency Mr. Minister of Health and brings together all Central Directors of directorates and programs, partners of the health sector, Doctors who are health inspectors in provinces, and Excellencies the Ministers of Health in the provinces, as well as other target staff and experts

Health sector review once a year:

This meeting evaluates the activities of the entire sector for the year that has passed; its composition is similar to that of the TCC

Regular program reviews:

Each program of the sector involving its staff and partners evaluates the level of completion of its program through a SWOT analysis and takes steps to improve the achievement of the objectives of the sector through the program

It is the same for regular surveys such as the Demographic and Health Survey (DHS) and the MICS which are conducted every 5 years to measure several indicators including impact indicators such as maternal and child mortality, etc.

2. Pour the provincial level:

Description of the different meetings is like it is for the central level but including the staff, experts, and partners of this level.

Bimonthly meetings of the Technical Secretariat of the Provincial Steering Committee (CPP);

Quarterly meetings of the Provincial Steering Committees;

Bi-annual meetings of the CPP;

Annual reviews of the provinces, once a year;

Regular reviews of program coordination.

3. For the peripheral level (Health Zone)

Monthly data monitoring in the HZ to prepare the monthly report of the National Health Information System (NHIS);

Monitoring action in immunization in every health area through community volunteers and the CN under the supervision of a member of the HZ office.

Monthly meetings of the management council of the Health zones;

Health Zone administrative council meetings twice a year, in the 1st quarter to validate the HZ action plan and in the 4th quarter to evaluate the activities of the year.

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

There is only one monitoring and evaluation framework for health as described above. The HSS monitoring and evaluation activities are well-coordinated with this framework. There are no HSS monitoring and evaluation activities that are carried out outside the ones for monitoring and evaluation of the sector. The data that we require for drafting the HSS report are collected as part of the monitoring and evaluation activities of the sector. These activities are, for example:

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1. Monitoring of activities is carried out on a monthly basis in the HZ while the activities are conducted on a quarterly basis in the Health Districts. During the meetings, the HZ present their data and receive feedback from the HD staff and other HZ.

2. At the provincial level, there are two half-yearly reviews every year (July and February). These half-yearly reviews are carried out as part of the functioning Provincial Steering Committee.

3. An annual review is held every year in the Capital. All provinces participate in this review. The national reviews are organized as part of the NSC-HS.

The main sources of information used in the regular reviews at different levels of the national health system constitute:

- Data of the National Health Information System (NHIS) analyzed during the different provincial health reviews, the National Health Sector Review, the different meetings of the National Steering Committee of the Health Sector (NSC-HS), the Technical Coordination Committee NSC-HS, as well as the GAVI HSS ad hoc Commission.
- EPI monthly, quarterly, and annual reports;
- Reports of the different regular surveys (MICS, DHS) and the joint report of WHO and UNICEF

8.4.5. Please specify the participation of the main stakeholders in the implementation of the HSS proposal (including EPI and Civil Society Organizations). This should include organization type, name, and role in the implementation process.

The Health Sector Coordinating Committee in DRC is called **the National Steering Committee of the Health Sector (NSC-HS).** This committee was created by the Ministerial order no. 1250 /CAB/MIN/079/N0V/2009 of November 3, 2009, regarding the creation, organization, and functioning of the National Steering Committee of the Health Sector in DRC, the order for which is part of a dynamic review process since December 2014. It includes the Technical Coordination Committee (TCC-HS) of the NSC-HS, as per Article 5, paragraph 2 of the said order. The NSC-HS includes the staff of the Ministry of Health at the central level and the intermediate level as well as the main partners of the health sector including the civil society at all levels of the Health Sector .

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For day-to-day management of the HSS proposal, the **NSC** delegated powers **to 6 members including: a representative** of the ministerial cabinet, the Secretary General of Health, the Director of the DSP; Representatives of the WHO and UNICEF as well as a delegate of the Inter Donor Health Group (IDHG). They meet along with the SG in a **Commission said to be Ad hoc** to discuss and decide on disbursements or problems that call for the opinion of one or the other, and the decisions are taken in a consensual manner.

The Civil Society Organizations (CSOs) participate in implementing the GAVI-HSS proposal at all the levels of the health pyramid of the DRC:

At the central level: they participate in the meetings of the NSC-HS to take part in the decision-making and the strategic guidelines for the implementation of the proposal. They took active part in reflecting upon the mass immunization campaigns against polio which is ravaging DRC head on.

At the provincial level: the **CSO** bring in their technical and managerial support to project implementation, particularly in the planning process and in localizing the HSSS, and they actively participate in the CPP meetings.

At the operational level (Health zones), the CSO are the actual field workers. They usually work with the target HZ where they bring in their technical and logistic support for implementing the activity in the field. Through their Representative (the Community Facilitators or CF), they participate in the meetings of the Management and Administrative Councils of the HZ, and encourage the population to frequent the health facilities in general and immunization facilities in particular through community volunteers. These community workers with the REZ and/or AVI approach recover all target children who have not come to the meeting and thus require motivation for it. For all these reasons, service contracts with specific indicators are signed for the purpose of further improving access to immunization services offered in the 516 HZ.

Also, to achieve the objectives of any project, the CSO are key, more so since they know the environment well and the situation in which the project is being conducted, therefore, their inputs are always desirable for the success of the program. The most participative organizations in HSS implementation are: the National Council of NGOs for health in DRC or NCNH as an acronym, the Congolese Red Cross, and the Health in rural areas or SANRU.

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

The CSO are the actual workers in the field. They usually work with the target HZ where they bring in their technical and logistic support for implementing the activity in the field. Through their Representative (the Community Facilitators or CF), they participate in the meetings of the Management and Administrative Councils of the HZ, and encourage the population to frequent the health facilities in general and immunization facilities in particular through community volunteers. These community workers with the REZ and/or AVI approach recover all target children who have not come to the meeting and thus require motivation for it. They actively participate in monitoring action in the health areas for intervention. The CSOs that have signed the contract with the MH for HSS funds: the National Council of NGOs for health in DRC or NCNH as an acronym and the Congolese Red Cross for a contractual amount of **$ 311,436** in 2014 including $ 28,834 of unused management fees, and awaited the entry of the new Financial Management Agency that is effectively working since December 2014.

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

- Was the management of the HSS funds has been effective?
- Where there any constraints in disbursing internal funds?

- What were the measures taken to address any issues and improve management?
- Are there any planned changes to management processes in the coming year?

1. Yes, management of the GAVI-HSS funds has become more and more effective with the restructuring of CAGF which must work towards a Financial and Administrative Directorate (DAF) in the long run, recruitment of the new AGEFIN with a performance contract contrary to the leaving AGEFIN, and implementation of 26 PHD that are closer to the HZ for the purpose of local support.

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3. As obstacles to internal disbursement of funds in 2014:

(i) Change in AGEFIN

(ii) Establishment of new PHDs

(iii) Restructuring of the CAG as CAGF.

(iv) Lack of and/or inadequate regular communication between the AGEFIN and the beneficiaries.

(v) Shortage of banks in most of the big cities for making uninterrupted fund transfers to the beneficiaries.

(vi) Average long distance of 300 km between the HZ and provincial AGEFIN / PHDs, the latter neither have motorcycles nor vehicles to use for movement and provide support to activities with the help of this funding and also support the district of Tanganika, South and North UBANGU.

(v) Cumbersome handling of applications at the AGEFIN and mistrust among AGEFIN and PHD

3. Among the measures taken were: (i) Capacity-building of experts at the Ministry of Health in financial management, drafting quality applications, signing performance contracts with the Provincial Financial Management Agencies, and bank transfers in place of financial messaging, (ii) Involvement of AGEFIN in the procurement process in accordance with the provisions of the Amendment II signed in July 2013 between MPH and KPMG, (iii) Equipping the provincial AGEFIN with motorcycles and or vehicles to facilitate their movement within the HZ. And (iv) Launching the recruitment process for a new coordinator of CAG through call for applicants, and for other staff of the CAGF.

4. As changes planned for improving management procedures in the following year: improvement in communication among agencies and beneficiaries by installing communication through website, involvement of all 26 provincial health divisions that play the role of payment authorizers like the CAG at the central level by signing performance contracts between the General Secretariat of Health and the 26 Provincial Health Divisions. Organizing monitoring at the AGEFIN by the General Inspectorate of Finances (IGF) and/or Audit Authority (AA).

8.5. HSS Activities planned for 2015

Please use **Table 8.4** to provide information on progress on activities in 2015. If you are proposing changes to your activities and budget in 2015, please explain these changes in the table below and provide explanations for these changes.

Table 8.4: Activities planned for 2015

Main Activities (insert as many rows as required)	**Activity planned for 2015**	**Original budget for 2015** (as approved in the HSS proposal or as adjusted during past Annual Progress Reviews)	**2015 actual expenditure** (as at April 2015)	**Revised activity** (if applicable)	**Explanation for proposed changes to activities or budget** (if applicable)	**Revised budget for 2015** (if applicable)

Activity 1.1	Purchase a modern central warehouse in Kinshasa with a gross capacity of 2,200 cubic meters of positive storage and 140 cubic meters of negative storage for storing vaccines for the entire country.	3,868,228	0			
Activity 1.2	Construct a dry warehouse at Kinshasa with a gross volume of 10,000 cubic meters and an area of 5,000 square meters for the dry inputs of 13 PHDs	1,500,000	0			
Activity 1.3	Purchase a modern decentralized sub-warehouse at Kisangani with a gross capacity of 480 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of the Eastern part of the country (8 PHDs)	799,508	0			
Activity 1.4	Construct a dry warehouse at Kisangani with a gross volume of 6,200 cubic meters and an area of 3,100 square meters for the dry inputs of 13 PHDs	930,000	0			

Activity 1.5	Purchase a modern decentralized sub-warehouse at Lubumbashi with a gross capacity of 160 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of Katanga	305,661	0			

Activity 1.6	Construct a dry warehouse at Lubumbashi with a gross volume of 3,030 cubic meters and an area of 1,515 square meters for the dry inputs of PHDs of Katanga	454,500	0			
Activity 1.7	Purchase a modern decentralized sub-warehouse at Ibedo with a gross capacity of 320 cubic meters of positive storage and 20 cubic meters of negative storage for storing vaccines required at the PHDs of Western and Eastern Kasai	552,604				
Activity 1.8	Construct a dry warehouse at Lubumbashi with a gross volume of 4,294 cubic meters and an area of 2,147 square meters for the dry inputs of PHDs of Western and Eastern Kasai	644,100	0			

Activity 1.9	Purchase solar-powering materials of a capacity of 40,000 watts to operate the cold chain equipment at the decentralized depot of Ibedo	429,975	0			
Activity 1.10	Ensure maintenance of the cold chain equipment at the central depot and the 3 decentralized depots	95,776	0			

Activity 1.11	Ensure maintenance of the cold chain equipment at the central depot and the 3 decentralized depots Purchase 4,000 battery-less solar refrigerators with a gross capacity of 20 to 50 liters for the Health Centers (PQS codes E003/020 and E003/039 of March 2014)	4,696,650	0			
Activity 1.12	Purchase spare parts for the 20-liter refrigerators (1 packet for 2 refrigerators) (PQS code E003/039 of March 2014)	210,000	0			
Activity 1.13	Ensure regular maintenance for 4,000 battery-less solar refrigerators at the Health Centers	135,000	0			

Activity 1.14	Purchase 250 SDD solar refrigerators-freezers of 278 liters for 250 depots at the Health zones with more than 180,000 inhabitants by 2025 (PQS code E003/030 of March 2014)	2,680,965	0			
Activity 1.15	Purchase spare parts for the 278-liter refrigerators-freezers (1 packet for 2 refrigerators) (PQS code E003/030 of March 2014)	110,329	0			

Activity 1.16	Ensure regular maintenance of 250 refrigerators-freezers at the depots of the HZ	25,000	0			
Activity 1.17	Ensure regular maintenance of 1,680 petrol-refrigerators currently present at the HZ during the transition from fossil fuel to solar energy	84,000				
Activity 1.18	Ensure solar-powering of 23 cold rooms for vaccines and of Regional Distribution Centers (RDC) for Drugs in PHDs deprived of electrical energy supply	2,760,000	0			

Activity 1.19	Increase approximately 1,350 cubic meters (650 square meters), storage capacities of 16 Regional Distribution Centers for Drugs (RDC) in PHDs where medicine and vaccine supply systems will be integrated and coordinated.	1,560,000	0			
Activity 1.20	Restore existing buildings identified with an area of 300 square meters (volume of 600 m^3) to create depots for dry inputs related to vaccines	1,980,000	0			

Activity 1.21	Ensure maintenance of cold rooms in PHDs	67,600				
Activity 1.22	Set up a continuous monitoring system with an alarm system in cold rooms of central and decentralized depots for vaccines	85,500				
Activity 1.23	Purchase 2 cold storage vessels of 480 cubic meters of positive storage, 20 cubic meters of negative storage and a dry storage volume of approximately 1,000 cubic meters	4,049,396				

Activity 1.24	Ensure transportation of vaccines from the central depot to the PHDs through decentralized depots (air and water transport including the operational cost of the vessel)	914,400				
Activity 1.25	Purchase 5 cold storage vehicles of 20 cubic meters and 16 trucks for transporting vaccines and dry inputs from the central depots and decentralized depots to PHDs including transportation from the 11 PHDs to the HZ	0	0			
Activity 1.26	Purchase 40 4x4 vehicles to complement the transport of vaccines, medicines, and other inputs from the PHDs to the HZ	0	0			
Activity 1.27	Purchase 50 125-type motorcycles for the target HZ	0	0			
Activity 1.28	Purchase 100 15-HP speedboats and canoes for immunization of riverside children, under specific strategies	0	0			
Activity 1.29	Purchase 250 100-type motorcycles for advanced strategies in Health Areas with limited accessibility	0	0			

Activity 1.30	Build capabilities of 35 maintenance engineers in the maintenance pools at the central level and the PHDs	110,075	0			
Activity 1.31	Train 125 logisticians integrated in the health sector (professional license level) for the 26 PHD and target HZ	343,750	0			
Activity 1.32	International technical assistance for feasibility studies of the central depot and 3 decentralized depots	247,500				
Activity 1.33	International technical assistance for logistics and effective vaccine management	0	0			
Activity 1.34	Purchase continuous temperature-monitoring equipment for 57 cold rooms for vaccines of PHD and central and decentralized depots (Cost reference: PQS E006/025 of March 14, 2014)	234,420	0			
Activity 1.35	Ensure sub-contracting for maintenance and day-to-day management of two cold storage vessels (in the beginning)	0	0			

Activity 1.36	Purchase 88 freezers of 1,000 liter capacity for recycling batteries in vaccine depots of PHD (PQS E0030/023 March 2014)	0	0			
Activity 2.1	Provide support in preparing Operational Action Plans that form the basis of 50 HSS-targeted HZ (REZ: Basic micro-planning)	199,000	0			
Activity 2.2	Provide integrated supportive supervision of management teams from Health Zones to Health Centers	135,000	0			
Activity 2.3	Restore 200 existing buildings of the Health Centers in 50 HSS-targeted HZ	0	0			
Activity 2.4	Equip 200 Health Centers to be restored	0	0			
Activity 2.5	Structural allocation for results based financing in 50 target Health Zones	3,060,000				

Activity 2.6	Contribute to organizing specific strategies (waterways, intensive expedited immunization work) aiming to completely immunize at least 100,000 very difficult-to-reach additional children every year in 9 identified PHD (Equateur, Tshuapa, Mongala, Maïndombe, Sankuru, Maniema, Tshopo, Tanganyika, and Haut Lomami)	750,000	0			
Activity 2.7	Provide support to advanced strategies in 750 Health Areas of 50 target HZ	135,000	0			
Activity 3.1	Equip the 8,830 Health Areas with health information collection tools (scorecards, immunization registers, and NPSU cards)	803,530				
Activity 3.2	Provide additional support to monitoring sessions and quarterly self-assessment for data in 8,830 Health Areas in 516 Health Zones	1,059,600				

Activity 3.3	Provide support to quality audit of data and to quarterly monitoring of coverage in 516 Health zones carried out by the PHD	795,672				

Activity 3.4	Ensure additional internet subscription of 516 Health Zones connected to V-SAT for widespread use of DHIS2 adapted to DVDMT and SMT.	278,640				
Activity 3.5	Organize small surveys for knowledge, attitudes, and practices, for coverage, and for access to health services in selected HZ to complement the quarterly reviews of the target PHD	200,000	0			
Activity 3.6	Organize the vaccination coverage survey as per the methodology encompassing all 26 PHD	0				
Activity 3.7	Provide support to PHD in the process of quality audit of HZ data	45,500				

Activity 3.8	Create quarterly scoreboards for monitoring the implementation of the NPMD including the 6 immunization indicators	22,500				
Activity 3.9	International technical assistance for support to the process of improving data quality	148,500				

Activity 4.1	Provide additional support to the planning process in the 5 target PHD (advocacy and OAP consolidation workshops)	200,000				
Activity 4.2	Provide additional support to integrated quarterly reviews of the PHD bringing together the HZ and the partners	300,000				
Activity 4.3	Provide additional support to CPP meetings of 5 target PHD	40,000				
Activity 4.4	Provide monthly support to HZ through the Multi-functional Provincial Supervisors in the target PHD	247,950				
Activity 4.5	Provide national technical assistance to coordinating and implementing the consolidated Action Plans of the 26 PHD	470,700				

Activity 4.6	Provide support in organizing the provincial ICC meetings and meetings of the integrated supply commission	11,250				
Activity 4.7	Provide support and coordinate the planning process in the sectors in order to create multidonor consensual OAPs at all levels	327,000				

Activity 4.8	. Provide technical support of the central level to the PHD in preparing and organizing quarterly reviews.	157,500				
Activity 4.9	Ensure joint monitoring of the implementation of the OAP in the 50 target HZ, by the GAVI HSS program every six months	187,500				
Activity 4.10	Provide support to the central level in preparing and organizing meetings of the Provincial Steering Committee of the Health Sector in the 5 target PHD under GAVI-HSS	22,500				
Activity 4.11	Ensure half-yearly monitoring of service activities and effective vaccine management in depots of the PHD	117,000				

Activity 4.12	Ensure half-yearly monitoring of vaccine coverage and morbidity due to vaccine-preventable diseases in PHD with problematic HZ	45,000				
Activity 4.13	Provide additional support in preparing and organizing half-yearly meetings of the National Steering Committee of the Health Sector	102,000				
Activity 4.14	Provide additional support in preparing and organizing annual sector reviews	151,500				
Activity 4.15	Ensure participation of MPH staff in the international forums in order to exchange experiences	10,544				
Activity 4.16	Participation in the international course in Planning, Monitoring and evaluation, Health economics, and Performance-based Management	32,000				

Activity 4.17	Ensure capitalization on experience in order to document the best practices, sustainability and viability of GAVI HSS program results in target PHD	61,500				
Activity 4.18	Conduct research and studies on the health system (pricing of healthcare, equality in access to health services, universal coverage, review of the provincial health expenses, National Health Accounts, etc.)	103,100				
Activity 4.19	Conduct two independent evaluations (mid-way and at the end) of the GAVI HSS program	0				

Activity 4.20	Provide support to the standardization process as well as consolidation of reform of PHD and the central level	51,750				
Activity 4.21	Organize 12 meetings of the Technical ICC at the central level	6,000				
Activity 4.22	Organize 12 meetings of the Strategic ICC at the central level	4,000				

Activity 4.23	Technical support to PHD in epidemiologic surveillance (reporting, handling, analysis, transmission, and sampling) and dispatch of samples to the provincial and national laboratories	22,500				
Activity 4.24	Provide support to collection, analysis, and publication of information on epidemiologic surveillance	22,500				
Activity 4.25	Ensure coordination of the process of regrouping programs specialized in the fight against diseases	22,500				
Activity 4.26	Organize the work to prepare the JRF and the Annual Progress Report at GAVI Alliance	40,800				
Activity 4.27	Ensure monthly functioning of the EPI	81,986				

Activity 4.28	Purchase 6 vehicles for coordinating the GAVI-HSS program (SG, DSP, EPI Directorate, Program Managers, EPI and DSP Monitoring Focal Points)	210,000				

Activity 4.29	Provide additional support to the work for preparing the NPMD 2016-2020	456,000				
Activity 4.30	Structural allocation for results based financing in central level facilities involved in the GAVI HSS2 program implementation (DSP, EPI, DLM, DNHIS)	480,000				
Activity 4.31	Structural allocation for results based financing in 5 target Provincial Divisions of Health	570,000				
Activity 4.32	Structural allocation for results based financing in 21 other Provincial Divisions of Health	273,680				
Activity 4.33	Provide support to the monthly meetings of the 6 commissions of the National Health Sector Coordinating Committee	54,000				

Activity 4.34	International short-term consultancy in the field of equality and instituting the universal health coverage	50,000				

Activity 4.35	Long-term technical assistance in viability of funding immunization in DRC	99,000				
Activity 4.36	International technical assistance to remove bottlenecks in immunization coverage in the PHD facing problems	99,000				
Activity 4.37	Organize a training session of 3 days in Management of immunization activities (DQS, EVM, immunization sessions, etc.) for 8,830 service providers	927,150				
Activity 4.38	Organize a training session of 14 days in MLM for 5 staff members of each of the new PHD	273,000				
Activity 5.1	Provide support to educating the households and/or recovering children ”12 months and pregnant women who are not immunized by RECO and Red-Cross volunteers in the 800 Health Areas in target HZ	56,205				

Activity 5.2	Train/Retrain members of HDC (RECO) and the volunteers of the Red Cross in EPI communication (with 3 Recos/HDC per Health Area)	289,842				
Activity 5.3	Build the capacities of identified CFO facilitators in managing their structures and in EPI communication (with 4 CFO per HZ)	94,500				
Activity 5.4	Provide support to creating awareness among households through media (audiovisuals)	70,000				
Activity 5.5	Provide support to creating awareness in public places through players in HDC and voluntary workers of the Red Cross	24,710				
Activity 5.6	Provide support to organizing monthly meetings of HDC	135,000				
Activity 5.7	Print and distribute the distinctive signs (T-shirt, Cap, etc.) for motivating community volunteers and members of CFOs.	0				

Activity 5.8	Print the materials for creating awareness and reporting for RECO and CFO (image boxes, counseling cards, notebooks, reporting forms, immunization cards, etc.)	0				

Activity 5.9	Equip the HZ and the CFOs with Kits for creating awareness - video forum (1 21” TV, I Overhead projector + Screen, 1 power generator, 1 LCD)	0				
Activity 5.10	Provide quarterly support to organizing assemblies of community workers in the HZ	213,000				
Activity 5.11	Support the functioning of CFO in reporting	6,750				
Activity 5.12	In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs	14,000				
Activity 5.13	Provide support to recovering children not yet reached by the Reco in the 50 target HZ	67,500				

Activity 5.14	Provide support to the awareness programs through local NGOs/CFOs in the HZ	11,250				
Activity 5.15	Equip the identified CFO network with an IT Kit (Computer, printer, accessories, etc.)	0				

Activity 5.16	Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences	6,250				
Activity 5.17	Organize advocacy efforts targeted toward political decision-makers in Provincial Governments and Provincial Assemblies of the target PHD	25,000				
Activity 5.18	Organize field visits for monitoring the HZ/HA by the consortium partners (on project implementation)	276,199				
Activity 5.19	Participate in the different Regional and International meetings on immunization.	13,000				
Activity 5.20	Participate in various integrated provincial reviews	5,400				

Activity 5.21	Bonus for the managerial staff of the team at least as committed under Project monitoring	450,000				
Activity 5.22	Bonus for the support staff of the consortium	180,000				
Activity 5.23	Equip CSOs with transportation material	175,000				
Activity 5.24	Equip CSOs with Office equipment	25,000				
Activity 5.25	Equip CSOs with IT Kits	25,000				
Activity 5.26	Provide support to awareness campaigns organized by RECO and Red Cross Volunteers during mass activities	168,750				
Activity 5.27	Ensure monthly functioning of CSOs (13% of the total budget for implementation activities of CSOs)	281,754				
Activity 6.1	AGEFIN management fees (7.5% of implementation activities by the MPH bodies outside the CAG)	1,015,061				
Activity 6.2	Program coordination management fees (SG-CAGDSP-EPI): 7.5% of implementation activities by the MPH	1,015,061				
		48,483,021	0			0

8.6. HSS activities planned for 2016

Please use **Table 8.6** to outline the activities planned for 2016. If you are proposing changes to your activities and budget (rescheduling) please explain these changes in the table below and provide explanations for each change so that the IRC can approve the revised budget and activities.

Please note that if the change in the budget is more than 15% of the approved allocation for the specific activity during the current financial year, these proposed changes must be submitted to the IRC for approval with the required proof.

Table 8.6: HSS Activities planned for 2016

Main Activities (insert as many rows as required)	**Activity planned for 2016**	**Original budget for 2016** (as approved in the HSS proposal or as adjusted during past Annual Progress Reports)	**Revised activity** (if applicable)	**Explanation for proposed changes to activities or budget** (if applicable)	**Revised budget for 2016** (if applicant)
Objectives 1 with same activities detailed in 2015	Strengthen the supply chain from end to end to ensure the availability of quality vaccines at all levels	12,692,127			
Objectives 2 with same activities detailed in 2015	Improve the availability of quality health services and 50 target health zones and the implementation of appropriate strategies to reach children in difficult to access areas in the 9 DPH identified.	9,369,500			
Objectives 3 with same activities detailed in 2015	Improve quality of data on health and the functional monitoring of activities in general and immunization in particular.	4,122,246			
Objectives 4 with same activities detailed in 2015	4. Strengthen the institutional capacities of the target structures at the Ministry of Health and the monitoring and evaluation mechanism at all levels.	4,854,845			

Objectives 5 with same activities detailed in 2015	Strengthen the demand for immunization needs by effectively implementing the communication plans and ensuring total participation of the community and organizations of the civil society.	3,018,954			
Objectives 6 with same activities detailed in 2015	Consolidate financial reformation and ensure program management	2,030,121			
		36,087,793			

8.7. Revised indicators in case of rescheduling

Countries planning to request rescheduling can do it at any time of the year. Please ask the your country's program managers at the GAVI Secretariat for guidelines on rescheduling or send an email to gavihss@gavi.org

8.8. Other sources of funding for HSS

If other donors are contributing to the achievement of objectives outlined in the GAVI HSS proposal, please indicate the amount and the links to inputs mentioned in the report:

Table 8.8: Sources of funds for HSS in your country

Donor	Amount in US$	Duration of support	Type of activities funded
British Cooperation (DFID)	56,000,000	5 years from 2013 to 2018	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Canadian Development Cooperation	3,500,000	3 years from 2013 – 2016	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Japanese Cooperation ou JICA	20,318,939	3 years from 2012 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
BTC (Belgian Technical Cooperation)	41,568,235	3 years from 2011 – 2014	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Global fund, Malaria	31,000,000	4 years, from 2012 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Global fund, HSS	8,681,527	4 years, from 2012 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Global fund, TBC	9,324,986	4 years, from 2012 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
PAPNDS	21,000,000	4 years, from 2010 to 2014	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)
Plan for strengthening the health system of the Congolese Government	85,000,000	3 years, from 2013 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)

USAID/PROSANI	140,000,000	5 years, from 2010 – 2015	strengthen the 3 levels of Healthcare system (CL, IL and operational levels)

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

8.9. Reporting on the HSS grant

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

- How the 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 questions were dealt with or solved.

Table 8.9.1: Data Sources

Data sources used in this report	How the information was validated?	Problems experienced, if any
Reports of the TTC-SS meeting and the Ad hoc Commission in 2014 as well as various DHS surveys 2013, Annual CSO report and Annual Report 2014 of CAGF & KPMG and the provinces.	Ad hoc Committee Meeting	no problem
Annual sectorial review report 2014 or NSC	Annual sectorial meeting	no problem
Various reports of the missions in the sector	debriefing meetings of the missions	no problem
Demographic and Health Survey 2013 and 2014	Meeting of the sponsors (MPH and Planning)	EPI administrative data for example are different from the data of these demographic and health surveys. But these data seem reliable.
Extracts of bank statements, principal account of the MPH and secondary account of AGEFIN	Meeting of the ad hoc committee and that of the technical coordination committee for the Healthcare System	No problem
CMYP revised 2015-2019	TTC-HS meeting	No problem
EPI annual Report 2014	Annual review of the program and the sector	Inconsistencies in the administrative data for central EPI and other sources (HZ, UNICEF and WHO and DHS 2013-2014),
Joint Report WHO and UNICEF	JRF meeting	No problem
Report of the National Health Information System (NHIS)	National review of the sector	inconsistency in the data provided, different from the survey data;
Reports of various provincial reviews in 2014	Annual meeting of the provincial steering committee	No problem

8.9.2. Please describe any difficulties faced 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.

Table 8.1.3b in local currency: the space assigned for entering the figures converted into Congolese Franc is insufficient. That's why this table is left blank.

The spacing should be improved to contain at least 12 digits.

8.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2014? Please attach:

1. The minutes from all the HSCC meetings held in 2015, endorsing this report **(Document Number: 6)**

2. Latest health sector review report **(Document number: 22)**

9. Strengthen the involvement of Civil Society Organizations (CSO): type A and type B

9.1. TYPE A: Support to improve coordination and the representation of CSOs

Democratic Republic of Congo (Kinshasa) **has NOT received GAVI Type A support for CSOs**

Democratic Republic of Congo (Kinshasa is not submitting a report on GAVI Type A support for CSOs for 2014

9.2. 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 B1 support for CSO Please list any abbreviations and acronyms that are used in this report below:

RCCA: Rotary Club of Congo Association

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HA: Health Area

BCG: Bacille Calmette Guerin

HDCO: Health District Central Office

BDOM: Diocesan Bureau of Medical Services

ICC: Inter-agency Coordination Committee

NCNH : National Council of Health NGOs

NSC: National Steering Committee

HDC: Health Development Committee

MC: Management Committee

COP: Chief of Party

RCDRC: Red Cross of the Democratic Republic of Congo

HC: Health Center

IC: Immunisation Coverage

DSP: Directorate of Studies and Planning

DTP: Diphtheria, Tetanus, and Pertussis vaccine

CCC: Church of Christ in Congo

ECZ: Health District Management Team

GAVI: Global Alliance for Vaccines and Immunization

GRH: General Reference Hospital

CN: Certified Nurse (Permanent nursing staff)

CFO: Community Foundation Organization

MDGs: Millennium Development Goals

NGO: Non-Governmental Organization

CSO: Civil Society Organization

CMYP: Complete Multi-Year Plan

DRC: Democratic Republic of Congo

RECO: Community Volunteers

HSS: Health System Strengthening

SANRU: Health in Rural Areas

MV: Anti-Measles Vaccine TTV: Tetanus Vaccine

9.2.1. **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 2014 rested on the following 4 strategic areas

- **Awareness campaign and recovery of children and pregnant women.**

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- **The strengthening for functionality of community participation structures**

- **Strengthening the participation of the local NGOs/targeted CFOs in immunization activities**

- **The advocacy for political decision-makers (governments and parliaments both at central and provincial level)**

As compared to these actions, the following progress was made:

- Training **192** local **CFOs**, **2370** community workers and Red-Cross volunteers in creating awareness about immunization and in recovery of children not yet reached and lost to sight, as well as in their involvement in management and coordination of immunization activities;
- A little over 165 CFO identified to this day whose members were trained and who are operational in educating and recovering activities through communication plans agreed with the HZs;
- 26 radio channels broadcast awareness messages at least once a week in the HZ and tuned in at the listening clubs constituted in the HA;
- In 33 support HZ, the community (RECO/RCDRC, CFO) participates in monthly monitoring meetings in the HA and the HDCO;
- The RECO/HDC/CFO organize pre-immunization visits (before the immunization sessions) in the households in order to identify children and pregnant women to be immunized
- Support to conducting joint advocacy missions (REPACAV, SVI, CSOs and PATH) targeted toward political decision-makers (national and provincial governments and legislative bodies) in order to create a new line in purchasing vaccines; in the provinces of Bas Congo, Maniema and Western Province.

These advocacy sessions particularly led to the involvement in transportation of vaccines to Western Kasai and to the signing of the social pact to the Eastern Province among various players in the province (Government, Assembly, Civil Society, EPI) for funding immunization.

- The effective implementation of a mechanism for recovery of not-yet-reached and lost-to-sight children through its network of Red Cross volunteers and community workers which in turn helped recover **120,014** unimmunized and/or lost-to-sight children and **18,621** unimmunized pregnant women who add to the increase in immunization coverage
- After 2 years of implementing communication activities in 33 HZs and based on the EPI data for 2014, the average dropout rate for DTP1-DTP3 is at 34.1% and the rate for DTP1-MV is at 9.1%.

31/33 intervention health zones were moved up to Category 1 and the remaining 2 stayed in Category 2 as indicated in the table below:

Classification of HZ / Category

January 2013

December 2014

No. of HZs

No. of HZs

Category 1

	9
	31
Category 2	
	11
	2
Category 3	
	6
	0
Category 4	
	7
	0
TOTAL HZs	
	33
	33

This progress was made possible with the help of various activities conducted by players in the field (HDMT, Healthcare service providers, etc.) and also after engaging and involving the community (members of the CFOs and basic community structures: HDC).

Please indicate any major problems (including delays in implementation of activities), and how these have been overcome. Please also identify the lead organization responsible for managing the grant implementation (and if this has changed from the proposal), the role of the HSCC (or equivalent).

1. Several problems marked the first year of project implementation:
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Regarding the project itself, we can mention:

Problems

Possible solutions

Delays in completing and promptly sending reports (program and financial)

Benefit from the opportunity of monitoring missions for active collection of data and supporting documents

Poor support by branches to management teams in health zones due to the absence of resources for conducting supervision missions

Provincial coordinations of NGOs of the consortium had to take charge of the teams at the branches and thus conduct joint supervisory missions for activities in the HZ.

Frequent stock-outs for some antigens: BCG and MV, YFV, PCV-13, and inoculation material. At the operational level.

With the funds remaining from 2013, and after the advocacy efforts targeted toward GAVI, the project could get permission to transport vaccines to the branches and intervention HZs.

The persistent insecurity in Eastern DRC having led to continuous movement of the people.

2. The main organization in charge of managing the utilization of funds.

In accordance with what was written in the application, the funds were transferred to the autonomous account that the COP, the body managing the project on behalf of the consortium leader (SANRU), had opened. This account is called, “SANRUGAVI-CSOs”. It is therefore, SANRU that manages the utilization of funds, through COP.

3. Role of the HSCC (its equivalent in DRC is NSC).

This project is a DRC government project for which the Technical Secretariat of the NSC will be the first to be in charge of coordination, monitoring, and quality control. Considering that the monitoring of immunization materials must require a certain level of expertise, the Technical Secretariat of the NSC works in coordination avec the ICC/EPI for monitoring and implementation of the project. Ultimately, the Technical Secretariat of NSC has the role of endorsing all annual and quarterly action plans of the partners, approving related budgets, analyzing various technical and financial reports that it receives from the COP, initiating financial audits of partners, and preparing annual reports and financial proposals addressed to GAVI.

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

Le Type B support to CSOs strengthened the collaboration with the Ministry of Health. In fact, the CSOs meet with the Ministry of Health representatives during the NSC and ICC meetings for regular discussions on the subject of implementation of different types of immunization support that the DRC receives. As for collaboration among the CSOs, this support helped among other things to set up a consortium of CSOs. This consortium is a framework for capacity-building of the NGOs involved and also the local CSOs guided by the project.

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At the operational level, the EPI considerably benefitted from the interventions of the NGOs and other Community-based organizations adequately involved in the implementation of primary healthcare activities which include immunization as one of the packages.

The structures of community participation gravitate toward two major entities: the HDC on one hand, and the Community-based Organizations on the other hand, CFOs.

HDCs are traditional organizations that support Health zones from the day following the establishment of the Primary Healthcare. Reformed, to this day, the HDC include the Community Volunteers, people from a community (respectable men of the village or the area, in popular opinion, altruistic, etc.) and from an institution (people designated by the institutions like schools, handicrafts) on the basis of their involvement in collective interests.

To this day, the HDC are organized into committees headed by the Chairperson, the Vice-Chairperson, a Secretary, and a Treasurer. They are active in Healthcare activities including immunization.

The CFO, Community-based Organizations, are varied, and exist for their own objectives of the religious order, also include some NGOs. In each HZ, the CFOs organized themselves into a network (at least 5 CFOs/HZ) and work in synergy with the HDC/RECO and Red Cross volunteers. These two structures of community participation work in synergy and are sufficiently appropriate for immunization activities to the point that they have become indispensable for immunization in the Health zones. They constitute a real link between the Community and the Healthcare services.

The support also helped the CSOs participate in monthly health zone reviews and HA where previous month's activities are evaluated and activities for the current month are planned. This is an important factor because the participation of Civil Society Organizations in this kind of meetings helps them make their voices heard by giving their point of view on the functioning of the health zone activities

Please specify whether the support has led to a change in the level and type of participation of CSOs in immunization and Health Systems Strengthening (give the current number of CSOs involved, and the initial number).

Apart from the 4 CSO involved in the consortium, this support helped to involve 165 local CFOs that hardly work particularly in the field on immunization. In fact, most of the CSO worked more in the field of HIV-AIDS and most of the community participation in the support to healthcare activities

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

With annual disbursement, this project did not face any problems from the finances point of view, however, the delocalization of HZ led to a late start of the activities because the status reports of these new HZ had to be prepared first.

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 they were previously involved in immunization 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 listed in the proposal.

Table 9.2.1a: Outcomes of CSOs activities

Name of CSO (and type of organization)	Previous involvement in immunization / HSS	GAVI supported activities undertaken in 2014	Findings

RCCA (NGO)	YES	Area 1: Awareness campaign and recovery of children and pregnant women. 1. Train the members of HDC (RECO) and Red Cross volunteers on the EPI communication strategy. 2. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (Educating the people nearby). 3. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 4. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 5. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 6. Support the organization of education sessions through local NGOs/recognized CFOs. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Provide support to the HA monitoring meetings every month. 3. Provide support to the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). 5. Support the advanced strategies. Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences	489 members of the HDC/RECO were trained on EPI communication. 22,254 children and 3572 Pregnant women are recuperated.

		Area 1: Awareness campaign and recovery of children and pregnant women. 1. Train the members of HDC (RECO) and Red Cross volunteers on the EPI communication strategy. 2. Build the capacities of recognized CFO facilitators in managing their structures and in EPI communication. 3. Provide support to creating awareness among	

NCNH (NGO)	YES	the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (educating the local people). 4. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 5. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 6. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 7. Support the organization of education sessions through local NGOs/recognized CFOs. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). 5. Support the advanced strategies. Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Help organize meetings among the local NGOs and CFOs in HZs to facilitate sharing of experiences. 4. Advocacy with policy makers (governments and parliaments both at central and provincial levels). 1. Organize advocacy efforts with decision-makers in Provincial Governments and Provincial Assemblies of Katanga, Western Kasai, Eastern Kasai, Eastern Province, and Equateur	488 members of the HDC/RECO were trained on EPI communication. 15,524 children and 2742 pregnant women are recovered. The HDCs create awareness. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. The CFO create awareness in the community on the basis of a communication plan. The community players meet once in a quarter to exchange experiences. The HDMT conduct monthly monitoring of monthly HDC activities. The local NGOs meet every quarter for sharing experiences. 124 political decision-makers reached through advocacy sessions

RCDRC (NGO)	YES	Area 1: Education and recovery of children and pregnant women. 1. Train the members of HDC (RECO) and Red Cross volunteers on the EPI communication strategy. 2. Build the capacities of recognized CFO facilitators in managing their structures and in EPI communication. 3. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (Educating the local people). 4. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 5. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 6. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 7. Support the organization of education sessions through local NGOs/recognized CFOs. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). 5. Support the advanced strategies. Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs.	514 members of the HDC/RECO were trained on EPI communication. 4,833 children and 834 pregnant women were recovered. The HDCs create awareness. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. HDC meetings. The CFO create awareness in the community on the basis of a communication plan. The community players meet once in a quarter to exchange experiences. The HDMT conduct monthly monitoring of monthly HDC activities. The local NGOs meet every quarter for sharing experiences.

		3. Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences.	

SANRU (NPA)	YES	Area 1: Education and recovery of children and pregnant women. 1. Train the members of HDC (RECO) and Red Cross volunteers on the EPI communication strategy. 2. Build the capacities of recognized CFO facilitators in managing their structures and in EPI communication. 3. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (Educating the local people). 4. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 5. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 6. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 7. Support the organization of education sessions through local NGOs/recognized CFOs. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). 5. Support the advanced strategies. Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings among the local NGOs	1,071 members of the HDC/RECO were trained in EPI communication. 77,403 children and 11,474 pregnant women are recovered. The HDCs create awareness. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. HDC meetings. The CFO create awareness in the community on the basis of a communication plan. The community players meet once in a quarter to exchange experiences. The HDMT conduct monthly monitoring of monthly HDC activities. The local NGOs meet every quarter for sharing experiences.

		and CFOs in HZ to facilitate exchange of experiences.	

Please list the CSOs that have not yet been funded, but are due to receive support in 2014/2015, with the expected activities and related outcomes. Please indicate the year you expect support to start. Please state if these CSOs are currently involved in immunization and/or health systems strengthening.

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

Table 9.2.1b: Planned activities and expected outcomes for 2014/2015

Name of CSO (and type of organization)	Current involvement in immunization / HSS	Activities that should be undertaken with GAVI support in 2014/2015	Expected outcomes
RCCA (NGO)	YES	Area 1: Awareness campaign and recovery of children and pregnant women. 1. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (educating the local people) 2. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 3. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 4. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 5. Support the organization of education sessions through local NGOs/recognized CFOs. 6. Train/Retrain the RECO and the Red Cross volunteers in the EPI communication strategy, in 20 HZ. 7. Build the capacities of recognized CFO in managing their structures and in EPI communication. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs.	Children and pregnant women not reached by the immunization service are recovered. Listening clubs are functional. Players of HDC create awareness in public places. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. The identified local NGOs/CFOs educate the community. The HDC meet every month for conducting their activities. The HA monitoring meetings are organized every month. The community players (community volunteers) and the CFOs in the HZs meet every quarter to share experiences. The HDMTs regularly monitor the HDC Advanced strategies are organized in the HA. The HA educate on the basis of their quarterly communication plans prepared in collaboration with the HZ. The local NGO/CFOs in the HZ meet once in a quarter to exchange experiences.

		2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences.	

NCNH (NGO)	YES	Area 1: Awareness campaign and recovery of children and pregnant women. 1. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (educating the local people) 2. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 3. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 4. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 5. Support the organization of education sessions through local NGOs/recognized CFOs. 6. Train/Retrain the RECO and the Red Cross volunteers in the EPI communication strategy, in 20 HZ. 7. Build the capacities of recognized CFO in managing their structures and in EPI communication. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences.	Children and pregnant women not reached by the immunization service are recovered. Listening clubs are functional. Players of HDC create awareness in public places. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. The identified local NGOs/CFOs educate the community. The HDC meet every month for conducting their activities. The HA monitoring meetings are organized every month. The community players (community volunteers) and the CFOs in the HZs meet every quarter to share experiences. The HDMTs regularly monitor the HDC. The HA educate on the basis of their quarterly communication plans prepared in collaboration with the HZ. The local NGO/CFOs in the HZ meet once in a quarter to exchange experiences.

RCDRC (NGO)	YES	Area 1. Awareness campaign and recovery of children and pregnant women. 1. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (educating the local people) 2. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 3. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 4. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 5. Support the organization of education sessions through local NGOs/recognized CFOs. 6. Train/Retrain the RECO and the Red Cross volunteers in the EPI communication strategy, in 20 HZ. 7. Build the capacities of recognized CFO in managing their structures and in EPI communication. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings among the local NGOs and CFOs in HZ to facilitate exchange of experiences.	Children and pregnant women not reached by the immunization service are recovered. Listening clubs are functional. Players of HDC create awareness in public places. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. The identified local NGOs/CFOs educate the community. The HDC meet every month for conducting their activities. The HA monitoring meetings are organized every month. The community players (community volunteers) and the CFOs in the HZs meet every quarter to share experiences. The HDMTs regularly monitor the HDC. The HA educate on the basis of their quarterly communication plans prepared in collaboration with the HZ. The local NGO/CFOs in the HZ meet once in a quarter to exchange experiences.

SANRU (NPA)	YES	Area 1: Awareness campaign and recovery of children and pregnant women. 1. Support educating the households and/or recovery of children and pregnant women who are inadequately immunized by RECO and Red-Cross volunteers during home visits (educating the local people) 2. Support the education of households through the media and listening clubs in areas not covered by Radio Frequencies. 3. Support awareness campaigns in public places through players of HDC (Community Volunteers, Volunteers of the Red Cross, and Opinion Leaders). 4. Support the awareness campaigns organized by RECO and Red Cross Volunteers during immunization activities that require a greater mobilization (AVI, mass campaigns, African Immunization Week, etc.). 5. Support the organization of education sessions through local NGOs/recognized CFOs. 6. Train/Retrain the RECO and the Red Cross volunteers in the EPI communication strategy, in 20 HZ. 7. Build the capacities of recognized CFO in managing their structures and in EPI communication. Area 2: Strengthening the functionality of community participation structures. 1. Provide support to organizing meetings of the HDC every month. 2. Support the HA monitoring meetings every month. 3. Support the quarterly assembling of the community workers (Community Volunteers) and the CFOs in the HZs. 4. Support the monitoring of HDC by HDMT (monitoring communication with the Community). Area 3: Strengthening the participation of the local NGOs/targeted CFOs in immunization activities. 1. In consultation with HDMT, support the development of communication strategies for the local NGOs/CFOs in HZs. 2. Support the educating activities for the local NGOs/CFO in HZs. 3. Provide support in organizing meetings of the local NGOs and CFOs in HZ for exchange of experiences	Children and pregnant women not reached by the immunization service are recovered. Listening clubs are functional. Players of HDC create awareness in public places. Support the awareness campaigns organized by RECO and Red Cross Volunteers during activities that require a greater mobilization. The identified local NGOs/CFOs educate the community. The HDC meet every month for conducting their activities. The HA monitoring meetings are organized every month. The community players (community volunteers) and the CFOs in the HZs meet every quarter to share experiences. The HDMTs regularly monitor the HDC. The HA educate on the basis of their quarterly communication plans prepared in collaboration with the HZ. The local NGO/CFOs in the HZ meet once in a quarter to exchange experiences.

9.2.2. **Future participation of CSOs in the health systems, plan of the health sector and immunization**

Please describe the participation of CSOs in the future planning activities and implementation of the health systems as well as the activities related to immunization. Justify and summarize the plans for CSO participation in these processes, including options and funding figures if possible.

If the country plans to use the funding platform of the health system, please describe the commitment of CSOs in this process.

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

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At the central level: they participate in the meetings of the NSC-HS to take part in decision-making and the strategic guidelines for the implementation of the proposal. The CSO works in collaboration with the EPI with whom they share the planning and progress achieved in implementation through the ICC meeting and through as well as through other meetings organized by EPI (meeting of the mid-term review or annual review of EPI, drafting of annual progress report, etc.) during which immunization related problems are discussed.

At the provincial level: the **CSO** bring in their technical and managerial support to project implementation, particularly in the planning process and in localizing the HSSS, and they actively participate in the monthly meetings of the Inter-Agency Co-ordination Committee (ICC); quarterly meetings of the PHD, HD, and the half-yearly meetings of the Provincial Steering Committees of the Health Sector(CPP-HS).

They also work in collaboration with the EPI branches in planning the (routine, AVI, and SIA) activities, joint monitoring of the activities at the HZ,

At the operational level (Health zones), the CSO are the actual workers in the field. They usually work with the target HZ where they bring in their technical and logistic support for implementing the activity in the field. Through their Representatives (the NGO especially the denominational ones because they are consequential in the community, the Community Foundation Organizations (CFO), the Health Development Committee HDC)), they participate in the meetings of the Management and Administrative Councils of the HZ and the HA, and encourage the population to frequent the health facilities in general and immunization facilities in particular through community volunteers and volunteers of the Red Cross.

These community workers with the REZ and/or AVI approach recover all target children who have not come to the meeting and thus require motivation for it. For all these reasons, service contracts with specific indicators are signed for the purpose of further improving access to immunization services offered in the 65 HZ under the GAVI HSS support.

The CSOs will also strengthen communication activities in the community to inform, raise awareness and thus minimize some socio-cultural barriers through the health development committees (HDC) and recognized community foundation organizations (CFO) as well as through the media.

Also, to achieve the objectives of any project, the CSO are key, more so since they know the environment well and the situation in which the project is being conducted, therefore, their inputs are always desirable for the success of the program.

9.2.3. Please provide the names of active CSOs in implementation, their contact details, and their representatives

RCCA: project focal point: Dr. Valentin Mutombo, bbmichaelmutombo@outlook.fr and Chairperson, Mr. Ambroise Tshimbalanga.

NCHN: project focal point: Mr. Laurent Mangala, cnosrdc@gmail.com and the Chairperson, Mr. Nestor Mukinay Tumtum

RCDRC: project focal point: Dr. Jean Faustin Balelia, jbalelia@yahoo.fr

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SANRU: focal point for the coordination unit: Dr. Benoit MIBULUMUKINI, benoitmibul@sanru.org project focal point for implementation: Dr. Assy Lala, assylala@sanru.org

9.2.4. **Receipt and expenditure of CSO Type B funds**

Please ensure that the figures reported below are consistent with financial reports and/or audit reports submitted for CSO Type B funds for the 2014 year.

	Amount in US$	Amount in local currency
Funds received in 2014 *(A)*	2,118,602	1,949,113,840
Funds remaining (carried over) in2013 *(B)*	658,181	605,526,639
Total funds available in 2014 *(C=A+B)*	2,776,783	2,554,640,479
Total expenditure in 2014 *(D)*	2,452,719	2,256,501,875
Balance carried forward to 2015*(E=C-D)*	324,064	298,138,604

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

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

Please include the details about: type of bank account(s) used (business or government account); budget approval procedures; how funds are directed to sub-national levels; provisions for preparing financial reports at the sub-national and national levels; and the overall role of HSCC in the process.

For the year 2014, the CSOs received direct funding from GAVI

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Management is executed based on the memorandums signed between the CSO and the COP and based on the manual of procedures (guidelines for implementation) established by the consortium.

The program CSO submit their requests for quarterly funds to the COP and disbursement is done according to the budget subject to the financial report and determined on the basis of the proof of consumption of at least 80% of the funds previously received; a funding request is expected to this effect with the help of the form.

Any adjustments in the budget or any other unforeseen transaction calls for an endorsement by the COP after submission for a competitive review between the latter and the CSO. The CSO is responsible for its management but the COP is responsible for monitoring the management of each CSO of the consortium and to make sure they adhere to the procedures.

The project activities are conducted in the provinces, the CSO of the consortium use the fund transfer agencies present in various provinces in order to help receive the funds at the provincial coordinations of the CSOs responsible for ensuring that they reach the HZ. The provincial coordination offices send all documentary proofs of activities conducted at their level to the national level of each CSO of the consortium. Thus, each CSO of the consortium prepares a financial report and sends it to the coordinating body of the COP consortium which then produces a consolidated Project report.

Problems faced:

- The Bank charges budget line was underestimated; during the transfer of funds from the GAVI account to the bank account of the COP, an amount to the order of US$ 4237.14 was retained as charges which exceeded the budget through the bank charges budget line to the order of 18.76% for the COP.

Given that the banks are not represented in all the provinces, fund transfers for field activities through the transfer agencies also results in an increase in the bank charges.

- There was an excess in the line for organizing an audit because we had to pay additional fees related to VAT given that the audit firm selected (Grant Thornton) is overseas.

NOTE:

The NGO NCHN and RCDRC received funds from the GAVI HSS project for quarter 1. In fact, the NCHN signed a collaboration agreement with the Ministry of Public Health to improve upon the involvement of the people in immunization activities.

The NCHN receives funds for activities quarterly, from the Financial Management Agency (AGEFIN) via the Management and Support Unit (CAG) of the Ministry of Health. The funds for activities for building capacities of community facilitators and for monitoring the activities are transferred directly to the account of NCHN opened at the TMB (Trust Marchands Bank) in Kinshasa.

Detailed expenditure of CSO Type B funds during the 2014 calendar year

Please attach a detailed financial statement for the use of CSO Type B funds during the 2014 calendar year (**Document No. 24)**. The financial statements will be signed by the main officer responsible for managing the type B CSO funds.

Has an external audit been conducted? Yes

External audit reports for CSO Type B program accounts should reach 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 must also be attached (Document number 25).

9.2.5. **Monitoring and evaluation**

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

These indicators must figure in the CSO application and reflect the contents of the cMYP and/or GAVI HSS proposal.

GAVI HSS proposal.

Table 9.2.5: Progress made in project implementation by CSO

Activity / outcome	Indicator	data source	Baseline Value and date	Current status	Date recorded	Target	Target Date
Provide support to the awareness programs by the	Number of awareness campaign sessions conducted	Activity report	2,078	1,875	12/31/2014	2,078	12/31/2014
Provide support to creating awareness among households through	Number of commercials and/or TV programs broadcasted	Activity report	1,320	1,292	12/31/2014	1,320	12/31/2014
Provide support to creating awareness among households and/or	Number of month GHQIDQWV" recovered	Activity report	135,224	120,014	12/31/2014	135,224	12/31/2014
Provide support to creating awareness among households and/or	DTP3 vaccination coverage rate	Activity report	90	99	12/31/2014	90	12/31/2014
Provide support to creating awareness among households and/or	MV vaccine coverage rate	Activity report	90	94	12/31/2014	90	12/31/2014
Provide support to creating awareness among households and/or	TTV2+ vaccination coverage rate	Activity report	90	104	12/31/2014	90	12/31/2014
Provide support to creating awareness among households and/or	Number of basic CSO participating in activities	Activity report	165	172	12/31/2014	165	12/31/2014
Provide support to creating awareness among households and/or	Number of pregnant women recovered	Activity report	23,622	18,621	12/31/2014	23,622	12/31/2014
Support awareness programs by RECO and Volunteers	Number of awareness campaigns organized	Activity report	4,310	3,982	12/31/2014	4,310	12/31/2014
Support the monitoring of HDC by HDMT	Number of HDC monitoring visits conducted by	Activity report	396	312	12/31/2014	396	12/31/2014

Provide support to organizing monthly meetings	Number of HDC meetings	Activity report	7,152	6,798	12/31/2014	7,152	12/31/2014
Support, in collaboration with the HDMT, the preparation of	Number of communication plans for the local NGOs	Activity report	132	124	12/31/2014	132	12/31/2014
Provide support to the monthly monitoring meetings	Number of HA monitoring meetings	Activity report	7,152	6,798	12/31/2014	7,152	12/31/2014
Provide quarterly support to organizing HA	Number of community assembly meetings held in	Activity report	132	124	12/31/2014	132	12/31/2014
Train the members of HDC (RECO) and the volunteers	Number of trained HDC members Number of volunteers	Activity report	1,788	2,370	12/31/2014	1,788	12/31/2014
Organizing meetings of the local NGOs	Number of meetings held for the local NGOs in the HZs	Activity report	132	124	12/31/2014	132	12/31/2014
Organize advocacy efforts with political decision-makers	Number of decision-makers reached through advocacy sessions	Activity report	139	132	12/31/2014	139	12/31/2014

Activities planned:

Please give details of 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.

In the consortium, a project monitoring and evaluation framework was designed. It defines, according to the health pyramid level, various indicators of the process and the results to be monitored, data collection tools, report transmission network, feedback mechanism, as well as the roles of different players including the beneficiaries.

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1. In the communities: The main beneficiaries directly participate in monitoring the indicators through the CFO network of their representatives at the meetings of HDC, MC, and other monitoring meetings organized in the HZ or the Health Area. The monitoring meetings in the health areas are held monthly.

2. At the peripheral level (HA and HZ):

Activities are conducted in the HA; the new encounters in the HA bringing together the Head Nurses, Assistant Nurses, and other community workers (HDC/RECO, Red Cross Volunteers, and the CFO) constitute the 1st step in performance monitoring and orientation; during these meetings, the community players present reports of their activities for validation.

In the HZs, apart from the supervisory visits of the HDMT to the HA, the monthly meetings between the HDMT and the Head nurses is an occasion to not just evaluate performance but also to train nurses who face problems, through experience-sharing.

The HDMT also organize quarterly meetings with the local NGOs and CFOs in HZ for exchange of experiences.

The project monitoring indicators at this level are:

- DTP3, MV, and TTV2+ vaccination coverage rate by the HA
- Number of unimmunized children recovered by the HA;
- Number of unimmunized women recovered by the HA
- Number of basic CSO participating in immunization activities by the HA;
- Number of awareness campaigns organized
- Number of home visits conducted by the RECO and the Red Cross Volunteers.
- Number of quarterly meetings organized in the HZ with the participation of the 3 community players. At the intermediate level (EPI branch)

Provincial Coordinations of CSOs of the consortium conduct monthly monitoring of activities in the HZ and HA and the central level of each CSO conducts quarterly monitoring.

Apart from consolidating the data, the quarterly meetings of the EPI-HDC Branches help analyze the

performance of each of the HZ and formulate recommendations.

In addition, support from the HZ is provided through joint monitoring missions of EPI branches & Health districts and the provincial coordinations of the CSO to help the Health zones perform better.

Project monitoring indicators are:

- DTP3, MV, and TTV2+ vaccination coverage rate by the HZ
- Number of unimmunized children recovered by the HZ;
- Number of unimmunized women recovered by the HZ
- Number of basic CSO participating in immunization activities by the HZ
- Proportion of project HZ with coverage more than 80%

4. At the central level

The CSOs organize quarterly meetings of the consortium and mid-term reviews to take updates and discuss difficulties faced, propose possible solutions or discuss ways of avoiding these difficulties, and to exchange experiences and lessons learnt among participants. CSOs also participate in various meetings of the ICC.

Project monitoring indicators are:

- DTP3, MV, and TTV2+ vaccination coverage rate by the HZ
- Number of not-yet-reached children recovered by the RECO and the Red Cross Volunteers;
- Number of lost-to-sight children recovered by the HZ
- Number of unimmunized pregnant women recovered.
- Coverage rates by the HZ, partners, and for the project.

10. Comments from ICC/HSCC Chairs

You can submit observations that you may wish to bring to the attention of the monitoring IRC and any comments or information you may wish to share in relation to the challenges you have faced during the year under review. These are in addition to the approved minutes, which should be included in the attachments.

11. Appendices

11.1. Annex 1 - ISS instructions

INSTRUCTIONS:

FINANCIAL STATEMENTS **FOR THE ALLOCATION OF NEW VACCINE INTRODUCTION** UNDER **IMMUNIZATION SERVICES SUPPORT (ISS)**

I. All countries that have received ISS/ new vaccine introduction grants during the 2014 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2014, are required to submit financial statements for these programs as part of their Annual Progress Reports.

II. The financial statements are prepared in accordance with the national standards for accounting; as a consequence, GAVI will not provide countries with one single template with pre-determined cost categories.

III. GAVI requires **at least** a simple statement of income and expenditure for activities conducted during the calendar year 2014, containing the points (a) through (f), below. A sample basic statement of income and expenditure is provided on the following page.

a. Funds carried forward from the 2013calendar year (opening balance as of January 1, 2014)

b. Income received from GAVI in 2014

c. Other income received during 2014 (interest, fees, etc.)

d. Total expenditure during the calendar year

e. Closing balance as of December 31, 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis summarizes the total annual expenditure for the year by your Government's own economic classification system, and relevant cost categories (for example: salaries and wages). The cost categories used shall be based on the economic classification from your Government. Please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of December 31, 2014(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 be audited/certified prior to their submission to GAVI. However, it is understood that these financial statements should be subjected to scrutiny during each country's external audit for the financial year 2014. Audits for ISS funds are to be submitted to the GAVI Secretariat 6 months following the close of the financial year in their respective countries.

11.2. Annex 2 - Example of income & expenditure of ISS

MINIMUM REQUIREMENTS FOR ISS FINANCIAL STATEMENTS AND FOR THE ALLOCATION OF A VACCINE INTRODUCTION 1

An example of income & expenditure statement

Summary Table of income & expenditure – - GAVI-ISS		
	Local Currency (CFA)	Value in USD*
Closing balance for 2013 (as of 31 December 2013)	25,392,830	53,000
Summary of income received in 2014		
Income received from GAVI	57,493,200	120,000
Interest based income	7,665,760	16,000
Other incomes (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure in 2014	30,592,132	63,852
Closing Balance on 31 December 2014 (Balance carried over to 2015)	60,139,325	125,523

* Enter the exchange rate at the opening on 01.01.2014, the exchange rate at close on 31.12.2014 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification** – GAVI ISS						
	Budget in CFA	Budget in US$	Actual Expenses in	Actual Expenses in	Variance in CFA	Variance in USD
Salary expenditure						
Wages and salaries	2,000,000	4,174	0	0	2,000,000	4,174
Payment of daily allowances	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 expenses						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

**The expense categories are indicative and included only as an example Each Government will provide financial statements in compliance with their own economic classification system.

11.3. Annex 3 - Instructions for HSS support

INSTRUCTIONS:

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

I. All countries that have received HSS grants during the 2014calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2014, are required to submit a financial statement for these programs as part of their Annual Progress Reports.

II. The financial statements are prepared in accordance with the national standards for accounting; as a consequence, GAVI will not provide countries with one single template with pre-determined cost categories.

III. GAVI requires at least a simple statement of income and expenditure for activities carried out during the calendar year 2014, taking into account the points (a) to (f), below. A sample basic statement of income and expenditure is provided on the following page.

a. Funds carried forward from calendar year 2013 (opening balance as of January 1, 2014)

b. Income received from GAVI in 2014

c. Other income received during 2014 (interest, fees, etc.)

d. Total expenditure during the calendar year

e. Closing balance as of December 31, 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarize total annual expenditure for each HSS objective and activity, as per your government's originally approved HSS proposal, with further breakdown by cost category (for example: salaries and wages). The cost categories used shall be based on the economic classification from your Government. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of December 31, 2014(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 exchange rate has been applied, and any additional 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 should be subjected to scrutiny during each country's external audit for the 2014financial year. Audits for HSS funds are to be submitted to the GAVI Secretariat 6 months following the close financial year in respective countries.

11.4. Annex 4 - Example of income & expenditure of HSS

MINIMUM REQUIREMENTS FOR THE HSS-SUPPORT FINANCIAL STATEMENTS:

An example of income & expenditure statement

Summary Table of income & expenditure – GAVI-HSS		
	Local Currency (CFA)	Value in USD*
Closing balance for 2013 (as of 31 December 2013)	25,392,830	53,000
Summary of income received in 2014		
Income received from GAVI	57,493,200	120,000
Interest based income	7,665,760	16,000
Other incomes (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure in 2014	30,592,132	63,852
Closing Balance on 31 December 2014 (Balance carried over to 2015)	60,139,325	125,523

* Enter the exchange rate at the opening on 01.01.2014, the exchange rate at close on 31.12.2014 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification ** - GAVI-ISS						
	Budget in CFA	Budget in US$	Actual Expenses in CFA	Actual Expenses in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wages and salaries	2,000,000	4,174	0	0	2,000,000	4,174
Payment of daily allowances	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 expenses						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTAL FOR 2014	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

**The expense categories are indicative and included only as an example. Each Government will provide financial statements in compliance with their own economic classification system.

11.5. Annex 5 - Instructions for CSO support

INSTRUCTIONS:

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

I. All countries that have received CSO - Type B grants during the 2014calendar year, or had balances of funding remaining from previously disbursed CSO-Type B grants in 2014, are required to submit financial statements for these programs as part of their Annual Progress Report.

II. The financial statements are prepared in accordance with the national standards for accounting; as a consequence, GAVI will not provide countries with one single template with pre-determined cost categories.

III. GAVI requires at least a simple statement of income and expenditure for activities carried out during the calendar year 2014, taking into account the points (a) to (f), below. A sample basic statement of income and expenditure is provided on the following page.

a. Funds carried forward from calendar year 2013 (opening balance as of January 1, 2014)

b. Income received from GAVI in 2014

c. Other income received during 2014 (interest, fees, etc.)

d. Total expenditure during the calendar year

e. Closing balance as of December 31, 2014

f. A detailed analysis of expenditures during 2014, based on your government's own system of economic classification. This analysis should summarize total annual expenditure for each partner of the civil society, per your government's originally approved Type B support to CSOs, with further breakdown by cost category (for example: salaries and wages). The cost categories used shall be based on the economic classification from your Government. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of December 31, 2014(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 exchange rate has been applied, and any additional 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 should be subjected to scrutiny during each country's external audit for the 2014financial year. Audits for the Type B support to CSOs funds are to be submitted to the GAVI Secretariat 6 months following the close of the financial year in their respective countries.

11.6. Annex 6 - CSO income & expenditure example

MINIMUM REQUIREMENTS FOR FINANCIAL STATEMENTS ON TYPE- B CSO SUPPORT:

An example of income & expenditure statement

Summary Table of income & expenditure – GAVI-CSO		
	Local Currency (CFA)	Value in USD*
Closing balance for 2013 (as of 31 December 2013)	25,392,830	53.000
Summary of income received in 2014		
Income received from GAVI	57,493,200	120.000
Interest based income	7,665,760	16.000
Other incomes (fees)	179.666	375
Total Income	38,987,576	81.375
Total expenditure in 2014	30,592,132	63.852
Closing Balance on 31 December 2014 (Balance carried over to 2015)	60.139.325	125.523

* Enter the exchange rate at the opening on 01.01.2014, the exchange rate at close on 31.12.2014 of the financial year and also indicate the exchange rate used to convert the local currency into USD in these financial statements.

Detailed Analysis of Expenses by economic classification ** - GAVI-CSOs						
	Budget in CFA	Budget in US$	Actual Expenses in CFA	Actual Expenses in USD	Variance in CFA	Variance in USD
Salary expenditure						
Wages and salaries	2,000,000	4.174	0	0	2,000,000	4.174
Payment of daily allowances	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 expenses						
Vehicles	12,500,000	26.090	6,792,132	14.177	5,707,868	11.913
TOTAL FOR 2014	42,000,000	87.663	30,592,132	63.852	11,407,868	23.811

**The expense categories are indicative and included only as an example. Each Government will provide financial statements in compliance with their own economic classification system.

12. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of the Health Minister (or delegated authority)	2.1	✓	Signature rapport GAVI 2014 - Ministres.pdf **File desc:** Signature of the Minister of Health OK **Date/Time:** 15/05/2015 07: 56: 13 **Size:** 543 KB
2	Signature of the Finance Minister (or delegated authority)	2.1	✓	Signature rapport GAVI 2014 - Ministres.pdf **File desc:** Signature of the current Finance Minister **Date/Time:** 15/05/2015 07: 57: 33 **Size:** 543 KB
3	Signatures of the ICC members	2.2	✓	Signature rapport GAVI 2014 - CCIA.pdf **File desc:** Signature of ICC members OK **Date/Time:** 15/05/2015 07: 58: 40 **Size:** 415 KB
4	Minutes of the ICC meeting in 2015 endorsing the Annual Progress Report 2014	5.4	✓	Compte rendu de la réunion d'adoption de RSA 2014 GAVI_nestor final 13 mai 2015.doc **File desc:** Minutes of the ICC meeting endorsing APR 2014 on May 8, 2015. **Date/Time:** 15/05/2015 07: 45: 31 **Size:** 692 KB
5	Signature of the HSCC members	2.3	✓	Signature rapport GAVI 2014 - CCSS.pdf **File desc:** Signatures of the HSCC OK except UNICEF that based its signature after reading the current audit report for the year 2014. **Date/Time:** 15/05/2015 07: 59: 36 **Size:** 263 KB
6	Minutes of the HSCC meeting in 2015 endorsing the Annual Progress Report 2014	8.9.3	✓	Compte rendu de la réunion d'adoption de RSA 2014 GAVI_nestor final 13 mai 2015.doc **File desc:** Minutes of the HSCC meeting that endorsed this APR 2014 on May 8, 2015 **Date/Time:** 15/05/2015 07: 47: 26 **Size:** 692 KB
7	Financial statement for the ISS funds (fiscal year 2014) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	6.2.1	✗	Etat financier allocation SSV.docx **File desc:** Financial statement for the ISS grant 2014 **Date/Time:** 05/14/2015 07: 38: 46 **Size:** 12 KB

8	External audit report on the allocation of ISS funds (fiscal year 2014)	6.2.3	✗	Rapport audit externe sur l'allocation de SSV.docx **File desc:** ISS grant external audit report 2014 **Date/Time:** 05/14/2015 07: 39: 35 **Size:** 12 KB

9	Post-introduction Evaluation Report	7.2.1	✗	Rapport PIE externe du PCV13 en RDC.pdf **File desc:** Post-introduction external evaluation report for PCV-13 in DRC **Date/Time:** 05/14/2015 07: 48: 22 **Size:** 1 MB
10	Financial statement for grants for introducing a new vaccine (fiscal year 2014) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	7.3.1	✓	Etat financier pour l'allocation d'introduction d'un nouveau vaccin.docx **File desc:** Financial statement for the allocation of funds for the introduction of a new vaccine in 2014 **Date/Time:** 05/14/2015 07: 41: 37 **Size:** 12 KB
11	External audit report for the allocation of funds for the introduction of a new vaccine (fiscal year 2014), if the total expenses in 2014 are greater than US$ 250,000	7.3.1	✓	Rapport audit externe sur l'allocation d'introduction d'un nouveau vaccin.docx **File desc:** External audit report the allocation of funds for the introduction of a new vaccine in 2014 **Date/Time:** 05/14/2015 07: 42: 58 **Size:** 12 KB
12	EVM/VMA/EVSM report	7.5	✓	RDC EGEV 2014 Rapport Final.pdf **File desc:** Final EVM RDC report 2014 **Date/Time:** 05/13/2015 07: 40: 10 **Size:** 2 MB
13	Latest EVM/VMA/EVSM improvement plan	7.5	✓	DRC_cEVM-IP_vs2.2_Pla Amélioration GEV 2014.pptx **File desc:** EVM DRC improvement plan 2014 **Date/Time:** 05/13/2015 07: 35: 56 **Size:** 789 KB
14	Status of the implementation of EVM/VMA/EVSM improvement plan	7.5	✓	DRC_cEVM-IP_vs.2.6_Mise en oeuvre GEV 2014.xlsx **File desc:** Implementation plan for improvement in EVM DRC 2014 **Date/Time:** 05/13/2015 09: 09: 44 **Size:** 65 KB
16	The cMYP is valid if the country requests for extension of support	7.8	✓	PPAC_Draft 1_ RDC 2015-2019_VA_GNM_Input HAMA_AugA_02 02 2015_PM.docx **File desc:** CMYP DRC 2015-2019 **Date/Time:** 05/14/2015 05: 14: 34 **Size:** 3 MB

17	The costing tool for the valid cMYP, if the country is requesting an extension of support	7.8	✓	cmyp_costing_tool_3 7_Matadi_Nov 2014_24112014_v3_WBM_Claudio_31 dec 2014.xlsx **File desc:** DRC_Costing Tool 20152019 **Date/Time:** 05/14/2015 05: 22: 18 **Size:** 3 MB

18	Minutes of the ICC meeting approving the extension of vaccine support, if applicable	7.8	✓	CR CCIA stratégique juillet 2014.docx **File desc:** Minutes of the Strategic ICC meeting chaired by the Minister of Health approving the extension of support to vaccines. **Date/Time:** 05/13/2015 01: 34: 11 **Size:** 80 KB
19	Financial statement for the HSS funds (fiscal year 2014) signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	8.1.3	✓	Compte principal GAVI RSS 19022015.pdf **File desc:** Financial statement for the HSS funds main MPH/DRC account **Date/Time:** 05/15/2015 12: 42: 38 **Size:** 772 KB
20	Financial statement for the HSS funds for the period January-April 2015 signed by the Chief Accountant or by the Permanent Secretary of the Ministry of Health	8.1.3	✓	Compte principal GAVI RSS 19022015.pdf **File desc:** Financial statement for the HSS funds main MPH/DRC account **Date/Time:** 05/15/2015 12: 44: 04 **Size:** 772 KB
21	External audit report on the allocation of HSS funds (fiscal year 2014)	8.1.3	✓	audit_externe_2014_avec_cabinet international Grand thorton.doc **File desc:** External audit for the year 2014, HSS. **Date/Time:** 05/14/2015 10: 30: 17 **Size:** 77 KB
22	Review report of the health sector - HSS	8.9.3	✓	PROCES VERBAL DE LA REUNION DU CNPSS 2014.pdf **File desc:** Minutes of the NSCHS meeting of December 12, 2014 **Date/Time:** 04/04/2015 05: 01: 46 **Size:** 580 KB
23	Census report - Type A CSO support	9.1.1	✓	RAPPORT DU RECENSEMENT TYPE A.pdf **File desc:** Census report - Type A CSO support, DRC **Date/Time:** 05/07/2015 06: 31: 19 **Size:** 290 KB

24	Financial statement for the allocation of Type B support to CSOs (fiscal year 2014)	9.2.4	✓	ETAT FINANCIER 2014.pdf **File desc:** Financial Statement 2014 for CSO **Date/Time:** 05/07/2015 06: 34: 31 **Size:** 1 MB
25	External audit report on the Type B support to CSOs (fiscal year 2014)	9.2.4	✓	RAPPORT AUDIT OSC.pdf **File desc:** External CSO audit report. **Date/Time:** 05/07/2015 06: 37: 49 **Size:** 303 KB

26	Bank statements for each program funded in cash or a cumulative bank statement for all programs funded in cash, if funds are kept in the same bank account, where the opening and closing balance for the year 2014 as of i) January 1, 2014 and ii) as of December 31, 2014 are given	0	✓	Extrait de compte gavi 2013-2015.pdf **File desc:** Extracts of the main GAVI HSS account of the MPH 2013 to 2015. **Date/Time:** 04/18/2015 07: 45: 24 **Size:** 3 MB
27	minutes_ of_ icc meeting_vaccin_change_presentation	7.7	✗	CR CCIA stratégique juillet 2014.docx **File desc:** Minutes of the Strategic ICC meeting chaired by the Minister of Health approving the change in the presentation of the pentavalent vaccine. **Date/Time:** 05/13/2015 01: 37: 23 **Size:** 80 KB
28	Explanation for changes in target population	5.1	✗	Justification for changes for target population.docx **File desc:** Justification for changes for target population **Date/Time:** 05/14/2015 08: 07: 01 **Size:** 12 KB
	Other documents		✗	Syntheses-Rapport_financier_GAVI_2014 2015_AGEFIN KPMG.xls **File desc:** Consolidated detailed financial statement 2014 and cumulative statement for past financial years presented by AGEFIN/KPMG **Date/Time:** 05/21/2015 07: 54: 48 **Size:** 194 KB LISTE DES PRESENCES REUNION GAVI 08 MAI 2015.pdf **File desc:** Attendance list for the APR 2014 meeting to adopt the HSS, ISS, and CSO sections for DRC on May 8, 2015 **Date/Time:** 05/14/2015 10: 35: 48 **Size:** 191 KB

				Niveau d'éxecution des recommandations de la missions GAVIAlliance du 16 au 23 juin 2014_nestor.xls **File desc:** Implementation plan for recommendations of the GAVI missions of June 2014 and its execution level **Date/Time:** 04/18/2015 08: 27: 18 **Size:** 39 KB
				Rapport briefing des cadres provinciaux et CNP-SS doc.doc **File desc:** Report describing the process behind the reforms in the Healthcare system of DRC December 2014 **Date/Time:** 04/18/2015 07: 49: 04 **Size:** 290 KB
	Other documents		✕	RDC_Rapport_Evaluation conjointe_29 09 2014_Final_GAVI.doc **File desc:** MPH-GAVI joint evaluation report of September 2014 showing a self-assessment of its Healthcare system including the Expanded Program on Immunization. **Date/Time:** 04/18/2015 08: 14: 34 **Size:** 1 MB
				Rapport Evaluation Projet GAVI – RSS 1.pdf **File desc:** HSS1-DRC evaluation report finalized by the School for Public Health at the University of Kinshasa, faculty of medicine, in April 2014. **Date/Time:** 04/18/2015 07: 53: 50 **Size:** 2 MB
				11.a. Rapport EDS-RDC 2013 2014 version finale.pdf **File desc:** final DHS report 2013-2014 of DRC which includes all key indicators of the health system. **Date/Time:** 04/18/2015 07: 59: 37 **Size:** 1 MB
				CR de la réunion du CCIA technique PEV du 19 décembre 2014 version nestor.doc **File desc:** ICC EPI meeting of December 2014 **Date/Time:** 05/13/2015 01: 45: 50 **Size:** 72 KB

				CR du 22 aout 2014 (1).doc **File desc:** TCC-HS meeting regarding CAG activities in August 2014 **Date/Time:** 04/18/2015 08: 11: 17 **Size:** 90 KB
				CR de suivi du 18 decembre 2014.doc **File desc:** TCC-HS meeting regarding the monitoring activities conducted by the financial management and support unit of the MPH in December 2014. **Date/Time:** 04/18/2015 08: 08: 32 **Size:** 83 KB
				Compte rendu de la réunion de restitution de la mission GAVI en RDC 20 juin 2014_nestor_finale avec amendements GAVI.doc **File desc:** TCC-HS meeting having only one point on the agenda, reinstitution of the GAVI mission in DRC, June 2014 **Date/Time:** 04/18/2015 08: 05: 44 **Size:** 87 KB

	Other documents		✕	Reunion Commission ad hoc oct 2014.pdf **File desc:** meeting of the Ad hoc commission adopting the latest disbursement of HSS1 in October 2014 **Date/Time:** 04/18/2015 08: 02: 58 **Size:** 486 KB
				Signature rapport GAVI 2014 - OSC.pdf **File desc:** Signature of CSO members OK **Date/Time:** 05/15/2015 08: 02: 06 **Size:** 584 KB