Democratic Republic of the Congo

Case Study

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The Global Alliance for Vaccination and Immunization

Health Systems Strengthening Tracking Study

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Acronyms

APR	Annual Progress Reports
ARCC	Association des Rotary Clubs du Congo (Association of Rotary Clubs of DRC)
BCG	Bacillus Caulmette Guerin
CCM	Country Coordinating Mechanism
CIDA	Canadian International Development Agency
CNOS	
CNP	National HSS Pilot Committee
CPP	Comités Provinciaux de Pilotage - Provincial Steering Committees
CRDRC	Croix Rouge de la République Démocratique du Congo (Red Cross of the DRC)
CRS	Catholic Relief Services
CSOs	Civil Society Organizations
cYMP	Comprehensive Multi-Year Plan
DEP	Department of Research and Planning
DRC	Democratic Republic of the Congo
ECC	Christian Churches of Congo
EPI	Expanded Programme on Immunization
EU	European Union
GARSS	Groupe d'Appui à la Stratégie de Renforcement du Système de Santé – Support Group for the HSS
GAVI	Global Alliance for Vaccines and Immunization
GIBS	Inter-donor Health Group
GoDRC	Government of the Democratic Republic of Congo
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German society for technical cooperation)
HCS	Hanoi Core Statement
HMIS	Health Management Information System
HPG	Health Partnership Group
HSS	Health System Strengthening
ICC	Inter-Agency Coordinating Committee
IMR	Infant Mortality Rate
IP -07-09	Interim 2007–2009 HSS Plan
IPRSP	Interim Poverty Reduction Strategy Paper
IRC	Internal Review Committee

ISS	Immunization Support Services
JICA	Japan International Cooperation Agency
LFA	Local Fiduciary Agent
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOU	Memorandum of Understanding
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organization
PHC	Primary Health Care
PMT	Project Management Team
PMU	Project Management Unit
PR	Principal Recipient
SANRU	Sante Rural, a civil society organization
SPH	Kinshasa School of Public Health
SRs	Sub-recipients
TOT	Training of Trainers
U5MR	Under-five Mortality Rate
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office of Project Services
WB	World Bank
WHO	World Health Organization
WG	Working Group

I. Executive Summary

The Global Alliance for Vaccines and Immunization (GAVI) was launched in 2000 to increase immunization coverage and reverse widening global disparities in access to vaccines. The partnership includes governments in industrialized and developing countries, the United Nations Children's Fund (UNICEF), World Health Organization (WHO), World Bank, non-governmental organizations (NGOs), foundations, vaccine manufacturers, and public health and research institutions working together to achieve common immunization goals. Health systems strengthening (HSS) grants are a relatively new addition to GAVI's funding portfolio. The GAVI Alliance created this new funding window in 2005 based on a multi-country study that identified system-wide barriers to higher immunization coverage. Currently, a total of US $800 million is available from GAVI for HSS to help countries address difficult health systems issues such as management and supervision; health information systems; health financing; infrastructure and transportation; and health workforce numbers, motivation and training.

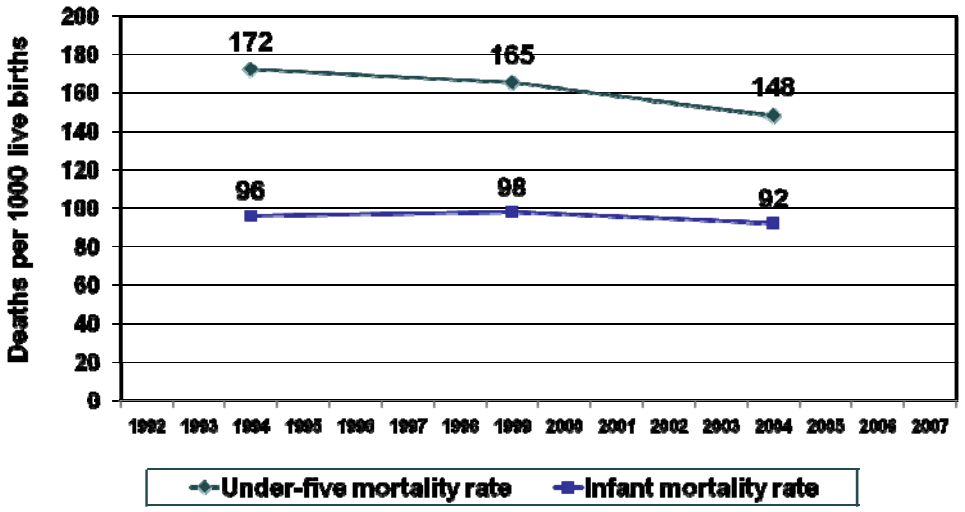
The GAVI Secretariat, along with its inter-agency HSS Task Team, sought an interim assessment of the HSS application and early implementation experience, with a focus on how countries are planning, budgeting and implementing their programs. With this purpose, GAVI awarded JSI Research and Training, Inc. (JSI) a contract to work with its partner organization in Sweden, InDevelop-IPM, to jointly implement the tracking study. The HSS tracking study has been designed to provide real-time evidence from the country level regarding the technical, managerial, and policy processes of GAVI HSS grant implementation. The tracking study spanned a period of 13 months (August 2008 to September 2009) and produced Case Studies in six HSS-recipient countries, including the Democratic Republic of the Congo (DRC).

DRC's overall health situation has deteriorated to the point that mortality and life expectancy levels are at a rate last experienced in the 1950s and 1960s. The country has one of the highest maternal and infant mortality rates in the world. Its maternal mortality rate was estimated at 1,289 per 100,000 live births.[1] Figure 1 shows the trends in under-five and infant mortality rates from 1992 to 2007. As the table shows, there were slight decreases in these rates over the past 15 years.

Child mortality is higher in conflict-affected regions. However, since the peace process began in the early 2000s, the overall child mortality situation in the war zones has started to improve, with under-five mortality declining from 408 per 1,000 in 2002 to 288 in 2003-2004[2].

[1] WHO Health Sector Needs Assessment, 2008.
[2] Ibid, World Bank 2005 report.

Figure 1: Trends in under-five mortality rates, Democratic Republic of Congo, 1992 to 2007



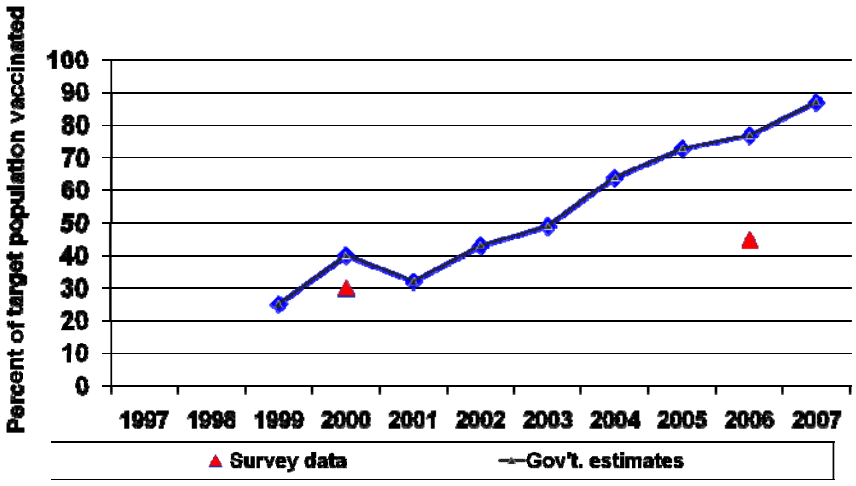
Source: Enquête Démographique et de Santé République Démocratique du Congo 2007
Note: Under-five mortality rates appear at the mid-point of the five year period for the estimate.

The majority of infant deaths are caused by preventable diseases, including respiratory infections, malaria, diarrhea, acute infections and measles, with malnutrition as a major factor. Malaria accounts for approximately 45 percent of infant mortality. Coverage of insecticide-treated bed nets is minimal, and there is growing parasite resistance to standard treatment.

As Figure 2 presents, according to the WHO 2008 Global Summary, the immunization coverage rate in DRC is high: 77 percent in 2006 and 87 percent in 2007. The Expanded Program for Immunization (EPI) has also reported high coverage data. With partial results for 2008, it is expected that coverage may drop to less than 85 percent, the program's target.

The 2006 and 2007 coverage rates were subsequently accepted at the global level, without modification, by WHO and UNICEF. However, there is reason to believe that the coverage in both years was seriously over-estimated. Preliminary results from the 2007 Demographic Health Survey (DHS) show DTP3 coverage to be only 45 percent and the DTP1-3 drop-out rate to be 36 percent, one of the highest rates in the world. The discrepancy in reported coverage and DHS survey findings is reason for serious concerns. Wild polio virus continues to circulate in the country, and the number of measles cases remains high, calling into further question DRC's coverage estimates.

Figure 2: DPT3 immunization coverage in DR Congo, 1999 – 2007



Sources: WHO vaccine-preventable diseases monitoring system 2008 global summary – country profile: DR Congo and Enquête Démographique et de Santé République Démocratique du Congo 2007.

Recently, when WHO compared DPT3 coverage for the first quarter of 2007 with coverage for the first quarter of 2008, it found that DRC was among the three countries in the WHO African Region where DPT3 coverage appeared to be on the decline.

Methods used in the Tracking Study included the collection of both qualitative and quantitative information to track the implementation of HSS activities. Study activities were initiated with two visits from members of the core study team to orient partners on study protocols and procedures and to generate operational details for the full implementation of the study (December 2008 and March 2009). Beginning in March 2009, the Kinshasa School of Public Health (SPH) conducted individual and group interviews, reviewed documentation and visited three HSS target provinces and select health zones (up to 13) to verify data and guide indicator selection and prioritization. The study team worked closely with MoH staff responsible for the GAVI HSS activities to determine data availability and assess the existing system for analyzing and presenting the data for HSS reporting. An HSS indicator tracking tool, linked to the HSS proposal indicators, was developed to assist the MoH in monitoring at the central-, provincial- and health-zone levels.

The DRC proposal was developed under the leadership of the MoH, with support from WHO, the Inter-Agency Health Donors Group (GIBS), the diaspora of Congolese health technicians working in the MOH, development partners and health NGOs. During the proposal preparation process, information exchange was inclusive and collaborative, and the proposal included adherence to the Paris Declaration and GAVI core principles. Under the current Round 8 application, the Government of DRC (GoDRC or the Government) has applied for HSS funding; the decision will be announced in October 2009.

The GAVI Alliance grants to the DRC began in 2002, with past and current commitments totaling US $183.2 million (to 2015) for injection safety, Immunization Services Support (ISS), vaccine introduction (for yellow fever, tetravalent and pentavalent), civil society support and HSS. The DRC application for HSS funding (US $56.8 million) was approved by the Alliance in October 2007. A first tranche of $21.5 million was transferred to the GoDRC in February 2008, followed by another tranche of US $20.1 million in April 2008. There are a number of donors involved in HSS activities in DRC, focusing their support on the health zone level. GAVI is the third largest donor of HSS funding in DRC after the World Bank, which provides US $150 million covering 83 health zones (out of 515 total in the country) and the European Union which provides US$ 100 million covering 60 health zones.

GAVI HSS funds in DRC are to be used to implement the strategy of revitalization and development of 65 health zones through:

- the rehabilitation of health facilities—representing 41 percent of the grant (including drugs for facilities) and
- the improvement of human resources through educational improvements and salary supplements—representing 25 percent of the grant.

In addition, there is support for three provinces and the central level. A multi-agency HSS National Steering Committee (CNP) was created to oversee implementation of the grant, and the Department of Studies and Planning (DEP) within the DRC Ministry of Health (MoH) has technical responsibility.

DRC's HSS grant aims to extend the National HSS Strategic Plan and address bottlenecks in the system to enable increased coverage of health services. Immunization coverage (DPT3 and measles) is considered to be a key indicator for the HSS. HSS implementation will also address other indicators and health programs (e.g., Integrated Management of Childhood Illnesses [IMCI], safe newborn delivery, nutrition) as part of an agreed-upon minimum package of services that should be provided and assured at the health zone level. The monitoring and evaluation process uses a number of the indicators within the existing health management information system (HMIS); however, there are several indicators included in the proposal that are not yet operational in the HMIS. In line with the capacity-building objective of the HSS Tracking Study, the SPH was contracted by JSI to develop a tracking tool to help guide data collection for the various indicators associated with the HSS.

Except for 10 of the 65 targeted health zones, GAVI funding will complement funding from other donors. The health zones were selected for the HSS with the aim of either maintaining existing levels or improving the performance of health services in the zones. Funding for the health zones will be administered through contracts with Congolese and international NGOS with presence in the health zones, as NGOs have a long traditional and strong capacity and presence of offering health services in DRC. HSS funds are being used as a launching point for health funding, accountability and sustainability within the MoH towards increasing the Government's allocation to health in the GoDRC budget. However, there is no detailed strategy to advocate for GoDRC's continued funding to ensure the sustainability of HSS activities once the GAVI Alliance grants end.

Since the GAVI funds were received in February 2008, there have been significant delays in implementation. The MoH and donor community have been working to create a project management unit within the MoH to provide overall financial management and oversight of large HSS funds (such as those from GAVI and the Global Fund[3]), with management by the DEP and oversight by the CNP.

Although the proposal described the steps and activities (e.g., define roles and responsibilities, processes and relationships with CNP and DEP) to recruit/select a fiduciary agent, whose role would be to disburse and account for funds to recipient organizations, the selection and set-up process have been slow. In the interim, the NSC/CNP and DEP authorized the use of HSS funding for large expenditures—e.g., equipment through United Nations Office of Project Services and pharmaceuticals through UNICEF—that are in the process of being delivered to the country.

In January 2009, the CNP and DEP selected a Cameroonian-based fiduciary agent after UNOPS pre-selected five candidates. However, contract clarifications have delayed signing the agent, with the result that Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (GTZ, German society for technical cooperation) was appointed on a temporary basis to assist with HSS financial management. In August 2009, the CNP, with the assistance of UNOPS in the identification and evaluation of several offers of competitive bids, selected and signed a contract with Audirex, a Cameroonian firm, to be the final fiduciary agent.

[3] Two previous proposals to obtain HSS financing from the Global Fund were rejected. Under the current Round 8 application, the GoDRC has applied for HSS funding, with a decision expected in October 2009.

In February 2009, CNP held the official launch of GAVI HSS, and DEP held a meeting with the health zones. During the meeting, the health zones were asked to send their health zone development plans and two-year budgets, based on a format provided by CNP and DEP. Provincial steering committees were to review these plans, and health zone support is to be managed through NGOs working in the zones. As of late July 2009, 50 plans and budget requests had been submitted. Once the CNP and DEP review and approve these plans, it is expected that the first tranche of funding will be released through Audirex to the NGOs in these health zones in the coming months.

A few challenges remain. Although norms are being discussed by CNP, a key question is how the health zones will address salary supplements (which will most likely be handled based on existing partners' practices). Also, the provincial steering committees did not provide their input on the plans and are not yet functional, as they have not yet received HSS support. Additionally, an HSS-funded, country-wide health zone situation analysis that was to be done as an initial step in HSS implementation is currently underway and is expected to provide its report by the end of 2009. As part of their HSS/DRC tracking study contract, the SPH also developed a draft operations research tool that is being reviewed for use by CNP to measure the impact of HSS funding (particularly salary supplements) on outputs and outcomes.

The burn rate for the GAVI HSS funds has been very low, with only US $108,520 spent by December 2008. US $14 million is expected to be spent by the end of 2009, to include payments for the equipment and pharmaceuticals purchased as well as the transfer of funds to the health zones, based on their health zone development plans. As Audirex may require time to set up its presence and systems in provinces and health zones to manage contracts with NGOs, this may affect funds transfers to NGOs and implementation.

Recommendations

The following summarizes a number of recommendations discussed during the July 2009 Country Case Study workshop held in Kinshasa:

a). To the CNP, DEP and Other Democratic Republic of the Congo Policy Makers

- Provide more information to stakeholders on HSS implementation issues.
- Learn and apply the civil society organization grant experience in DRC as a model for funds disbursement, financial management and implementation.
- Create links between the new MoH Programme Management Unit (PMU) and the fiduciary agent to ensure that the fiduciary agent transfers his/her knowledge and practices to the PMU.
- Put in place the audit systems (as described in the HSS proposal) to ensure that issues are detected early rather than towards the end of the project.
- Provide the necessary support to provinces (as written in the HSS proposal) to ensure that health zones are being supported and supervised.
- Harmonize and standardize the salary supplement component of the funds that are to be distributed to the health zones.
- Use the two tools (HSS indicator tracking and the operations research draft) developed by the SPH and ensure that there are HSS funds available for the proposed operations research**.**
- Operationalize the human resources component of the GAVI HSS grant, as the focus has not been on this part of the approved and funded strategy submitted by CNP.

Keep stakeholders and donors updated on HSS implementation issues.

b). To GAVI

- Ensure that there is an existing financial management structure in place to enable proper fund flows to recipients and proper financial management.
- Request a timeline for the set-up/operationalization of the financial management structure.

The MOH added two additional recommendations for GAVI:

- Should a country HSS financial management structure not exist already, consider a two-phase grant mechanism that enables the country to set up a structure and then provide funds for implementation in a second phase.
- Disseminate DRC's experience, including that with the Civil Society Organization (CSO) grant, through a Knowledge Management mechanism.

c). To Other Countries Applying for GAVI HSS Funds

- As was the case with the GAVI process in DRC, have a master HSS plan prior to initiating the proposal writing.
- Have a financial management system in place prior to manage large funds prior to the application for GAVI HSS funds or upon the implementation. Countries should avoid having to go through a process of creating a whole system of funds management and oversight to avoid implementation delays.

II. Introduction

a). Description of the GAVI HSS funding

The overall objective of the DRC HSS proposal is to address operational problems in the health zones [4] that impede improvements in immunization coverage; maternal, newborn and child health; and health care in general. Through this assistance to the health zones and some support to provincial and central levels, GAVI HSS aims to serve as a catalyst for further health sector improvements, with the goals of:

- Sustainable improvement in immunization coverage,
- Reduced reliance on the commercial care sector, and
- Re-establishment of essential public services.

To this end, the proposal follows the priority areas and intervention strategies laid down in the Interim 2007–2009 HSS Plan (IP 07-09), with particular attention to the complementarity between the GAVI support and the actions of the Government and other partners—the aim being to obtain comprehensive and efficient support for a maximum number of the country's health zones. In the present context, all of the partners consider the sustainable establishment of public interest health structures to be an essential element in the pacification and stabilization of the country, which is dependent on building up the capacities of the country's cadres and structures.

The proposal covers the last 3 years of the 10-year plan for the period 2000-2009, as well as a transition period in 2010, which will serve as a link with the next planning cycle for 2010-2019. The proposal envisages an overall budget of **US** $**56,812,806.**

The specific health system development objectives of the proposal are to:

- improve the supply and utilization of quality health services and ensure their financial and economic viability in the Democratic Republic of Congo by 2009,
- promote maternal, newborn and child health in the Democratic Republic of Congo by 2009,
- strengthen the prevention and cover of major endemic and epidemic diseases in the Democratic Republic of Congo by 2009.

The GAVI HSS support is aimed at implementing several aspects of the IP 07-09, namely:

1. ***The organization and implementation of the strategy for the revitalization and development of health zones, with***

   1.1. Support for the organization by the central and intermediate levels of the development of the health zones in three provinces for the sum of US $5,117,000 or 9 percent of the total package.

   1.2. Support for the implementation of the strategy for the revitalization of 65 health zones in seven provinces for the sum of US $22,908,500 or 40 percent of the total package.

2. ***Human resources for the sum of US $18,376,940 or 32 percent of the total budget.***

   2.1. Support for the development of policies and a set of measures to deal with the problem of human resources.

[4] A health zone in DRC is equivalent to the district health level in most other countries. Currently, there are 515 health zones in the country.

2.2. Support for the setting in place of direct interventions on human resource issues in 50 health zones, as well as in the health districts not in receipt of support by the present funding partners or intervening parties.

The estimated beneficiary population of women and children targeted through the health zones support is 11,704,343, representing approximately 17 percent of DR Congo's total population.

b). Objectives of the HSS Tracking Study

The GAVI HSS Tracking Study was designed to improve the quality of project design and applications, strengthen implementation, reinforce in-country monitoring of GAVI HSS, and promote integration of HSS into ongoing processes in DRC's monitoring and evaluation system. These objectives were addressed through the development of tools provided to the Division of Research and Planning (Division d'Etudes et de Planification, DEP), the HMIS group in the Division of Primary Health Care and the EPI program.

c). Study methodology

In addition to those on the JSI core study team, the University of Kinshasa School of Public Health (SPH) provided input into the monitoring tools and reviewed implementation and planning in the provinces and health zones. Their findings were included in the country workshop held in Kinshasa on 31 July 31 2009.

The DRC case study was conducted in two phases.

Phase I, conducted from September 2009 to March 2009, focused on project start-up activities aimed at orienting the SPH to study protocols and procedures, preparing the implementation phase of the study, and obtaining substantive baseline information. Two external visits were conducted, the first in December 2009 by two JSI core study team members and another, shorter visit in March 2009 by one member to update the information received during the December visit and begin planning the Country Case Study workshop. During this phase, communications also continued via telephone and email to update developments in the HSS implementation.

Phase II was initiated in March 2009, with the SPH focusing on data collection and tool development, including:

- Individual and group interviews (e.g., with the DEP, the HMIS focal point, and members of the National HSS Pilot Committee [CNP]), document review, and visits to five HSS target provinces and 13 health zones to verify data and guide indicator selection and prioritization. Through group and individual interviews, over 150 individuals responded to questions about the Tracking Study themes. (Annex 1)
- Collaboration with the HMIS focal point, DEP, and the Division of Disease Control and Surveillance to determine what data are being collected for the HSS, which indicators are needed or incomplete, and what the existing system for analyzing and presenting the data for HSS reporting is.
- Development of an HSS indicator tracking tool (linked with the HMIS and the HSS proposal indicators to assist the DEP and CNP with monitoring at central, provincial and health zones levels).

d). Description of the review process, including Country Workshop

The HSS Tracking Study documented DRC's HSS experience to date and provided feedback to assist with improvements in the processes and results. Qualitative and quantitative information were collected and analyzed, both retrospectively and prospectively, beginning from the commencement of the application process in country through the current implementation and monitoring and evaluation processes.

On 31 July 2009, the SPH and DEP organized a half-day DRC HSS workshop to share the findings of the DRC Case Study and receive feedback from various stakeholders, including the DEP, Government, CNP and donor partners. During the workshop, SPH briefly introduced the tracking and operations research tool to be made available to the DEP, the HMIS and discussed transcripts of interviews with front-line providers about issues they faced in funds disbursement, vaccines and cold chain interruptions.

Over 45 invitations were sent before the workshop, and 20 stakeholders attended[5]. During the workshop, stakeholder actively participated, contributing to the recommendations (refer to the Conclusion of this report). One of the workshop's key findings was that the DEP and CNP were not keeping other MoH departments sufficiently informed on the progress of implementation.

[5] As the timing of the workshop was during the vacation period, some stakeholders were unable to attend as they were on leave outside of the country.

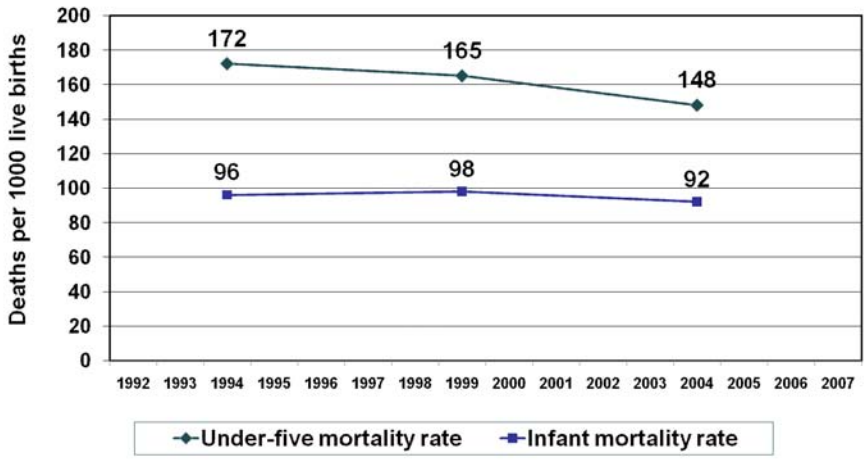
III. Country Context

a). Health situation, priorities and programs

DRC's overall health situation is weak, with mortality and life expectancy matching levels from the 1950s and 1960s. The MDG indicator levels in DRC are worse than those from other large and poor countries in sub-Saharan Africa[6].

The DRC has one of the highest maternal and infant mortality rates in the world. MMR was estimated at 1,289/100 000 live births (UNFPA estimates for 2007) [7] Figure 1 shows the trends in under-five mortality (U5MR) and infant mortality rates (IMR) from 1992 to 2007. The data shows a slight decrease in U5MR over the past 15 years. Child mortality is higher in conflict-affected regions. However, since the peace process began in the early 2000s, the overall child mortality situation in the war zones has started to improve, with under-five mortality reportedly declining from 408 deaths per 1,000 in 2002 to 288 in 2003-2004[8].

Figure 1: Trends in Under-five Mortality Rates, Democratic Republic of Congo, 1992 to 2007



Source: Enquête Démographique et de Santé République Démocratique du Congo 2007
Note: Under-five mortality rates appear at the mid-point of the five year period for the estimate.

The majority of infant deaths are caused by preventable diseases, including respiratory infections, malaria, diarrhea, acute infections and measles, with malnutrition a major contributing factor. Malaria accounts for approximately 45 percent of infant mortality, with estimated annual deaths between 150,000-200,000. Although increasing through various initiatives, coverage with insecticide-treated bed nets remains insufficient, and there is growing parasitic resistance to standard treatment. The total fertility rate (TFR) is also very high: 7.1.

[6] Democratic Republic of Congo Health, Nutrition and Population: Country Status Report, World Bank, 2005.
[7] WHO Health Sector Needs Assessment, 2008.
[8] Ibid, World Bank 2005 report.

b). Structure of the national immunization program and recent immunization coverage trends

The EPI institutional framework is outlined by a Ministry of Health decree that regulates the organization and operation of the program at the central and provincial levels[9]. The central level is responsible for setting standards and regulations, and the intermediate level is responsible for coordination, supervision and inspection.

The EPI is under the Fourth Directorate, responsible for Disease Control and Surveillance. As with other vertical programs in DRC, there are operational and coordination challenges with this organizational link. Table 1 presents the composition of the EPI program (as of October 2008). Over three quarters of the EPI staff are in the provinces and antenna[10] levels.

Table 1: Composition of EPI Staffing – October 2008

Position Title	Central level	Provinces and Antennas	TOTAL
Director	1	-	1
Deputy Director	1	-	1
Division Chiefs	4	11	15
Unit Managers	17	40	57
Technical Staff (Section 1)	44	75	119
Technical Staff (Section 2)	14	68	82
Administrative Staff	18	144	162
TOTAL	**99**	**338**	**437**

There are 437 managers and agents, including 99 (a reduction from 119 in 2005) at the central level and 338 (an increase from 287 in 2005) at the intermediate (provincial and antenna) and peripheral (health zone) levels. There are 11 offices corresponding to the 11 provinces and 43 antennas throughout the country. In terms of functionality, however, 60 percent of the branches have inadequate facilities and equipment (offices, vaccine depots, communication equipment, etc).

Coordination at the national level is through the immunization Inter-Agency Coordinating Committee (ICC) chaired by the Ministry of Health, with most of the partners supporting EPI as members. The ICC is supported by a technical sub-committee that guides technical support in immunization (including operational and program activities, communication and social mobilization, finances and logistics). A Memorandum of Understanding for immunization, outlining the obligations of each partner as well as those of the Government, is signed each year.

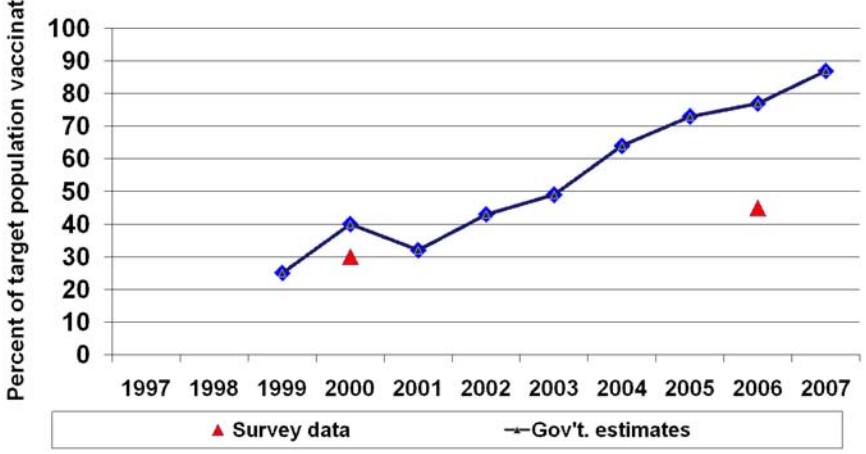
[9] AB/MIN/FP/JMK/PP/044/2003

[10] The antenna level is a unit within the EPI, under the provincial level, that serves as a programmatic and operational management and supervision unit for a collection of approximately 10 health zones.

Immunization Trends

Figure 2 shows an increasing rate of DPT3 immunization from 1999 to 2007.

Figure 2: DPT3 Immunization Coverage in DR Congo - 1999 – 2007



Sources: WHO vaccine -preventable diseases monitoring system 2008 global summary – country profile: DR Congo and Enquête Démographique et de Santé République Démocratique du Congo 2007.

As reported by the EPI program (see Annex 2), rates were exceptionally high in 2006 (77 percent) and 2007 (87 percent). The partial results for 2008 are expected to show that coverage has dropped to less than 85 percent, the program's target. Due to a lack of survey data for comparison, the 2006 and 2007 reported coverage rates were accepted by WHO/UNICEF at the global level, without modification (see Annex 3). . There is reason to believe that coverage in both years has been over-estimated. This is common in a number of countries, with administrative data reportedly higher than survey data, when available. For DRC, Annex 3 presents 2007 DHS data (preliminary results) showing DTP3 coverage to be only 45 percent and the DTP1-3 drop-out to be 36 percent—one of the highest rates in the world. Annex 4 presents analyses of DPT3 coverage estimates from 1990 to 2005, showing differing coverage rates by source (Institute of Health Metrics and Evaluation, University of Washington).

This discrepancy in reported coverage and DHS survey findings is reason for serious concern. Wild polio virus continues to circulate in the country since its re-emergence in 2007 (after an interruption of approximately four years), and the number of measles cases remains high, calling into further question DRC's coverage estimates. Additionally in 2007, 55,577 measles cases were reported, most of them in Katanga, North Kivu, Kinshasa and Orientale.

Recently, when WHO/AFRO compared DPT3 coverage for the first quarters of 2007 and 2008, they found that DRC was among the countries in the region where DPT3 coverage appeared to be declining.

As in many other African countries, vaccination coverage figures in DRC are difficult to estimate with precision. Immunization data are collected at the health-facility level, sent monthly to the central office of the health zones and then compiled and sent by the health zones to the EPI antenna and/or directly to the national EPI office (statistics unit), where the information is consolidated. Key issues affecting immunization data quality include:

- Multiple denominators - The target population numbers for immunization are not known precisely, and there has not been a national census since 1984. In many cases, target population estimates at the health zones level are not accepted by the national EPI officials at the central level. Instead, national-level officials send population estimates and targets

to health zones for planning purposes. At the health zone level, it is not uncommon for health workers to have two target populations: the one they received from the national level and the one calculated by the health zones. This produces coverage estimates at both zonal and national levels that may differ even though the number of immunized children is the same.

- Completeness and timeliness of reports - Problems in this area are often due to communication and logistics problems with transmitting data and sending reports. At the lower levels of the health system, there is also no clear guidance on what to do with reports that arrive late.
- Data quality - Spot checks of reported data often show discrepancies that raise questions about its validity, with over-reporting a common problem.
- In-country validation process - WHO and UNICEF staff in country use administrative reports from the national EPI and then work with EPI staff to validate or revise reported coverage rates, which they then report on the Joint Reporting Form to WHO and UNICEF. When changes are made to reported data, the reasons are not always clear or documented.
- Incentives for over-reporting - Since 2002 (when the country was approved for GAVI ISS, NVS and INS funds, DRC has received US $20 rewards from GAVI ISS funds based on each additional child immunized with DPT3. The more DPT3 doses given to children, the more funds the country received as a bonus from GAVI. This may have been an incentive for over-reporting DPT3 coverage. If this was the case, there is a political implication in reporting lower coverage than in past years.

It is hoped that one of the effects of the health system restructuring—with implementation managed through provincial ICCs—will be that the organization of monthly meetings. During these meeting, data from provinces are analyzed and discussed (data collection, compilation, completeness and timeliness and interpretation), with feedback sent to the health zones. This practice of holding monthly meetings and discussing data was stronger in the past and helped to improve the data quality, immunization performance and sharing of information (technical and financial) among the EPI partners at all levels.

IV. Implementation Experience

Table 2 shows the type, funding level and duration of each GAVI grant in the DRC. The two largest grants are for Health Systems Strengthening and pentavalent vaccine introduction.

Table 2. GAVI Alliance Support - Democratic Republic of Congo

Type	*Total value (U.S. $)*	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Vaccine introduction grant	931,500	✓													
Pentavalent vaccine	45,137,000							✓	✓						
Tetravalent vaccine	11,918,000						✓	✓							
Yellow Fever vaccine	27,956,000		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Civil society Support Type A and Type B	5,318,520							✓	✓						
Injection Safety	3,258,400		✓	✓	✓										
Immunization support services	29,300,280	✓	✓	✓	✓	✓	✓	✓	✓						
Health systems strengthening	62,133,500						✓	✓	✓						
Total	**183,126,200**														

Civil Society Organization Grant

The first year of CSO funding was received in 2008 and distributed, with activities linked to the HSS and health sector strengthening plans. Each CSO is managing the implementation and tracking of its HSS-supported activities, with the SANRU (Sante Rural) CSO serving as the consortium lead for the collection and compilation of summary reports submitted to the HSS Steering Committee and GAVI. The disbursement of funds to the CSOs and the implementation of activities are being well executed.

CSO funding comes from GAVI to UNICEF and the EPI account. The funds are then transferred to SANRU as the CSO consortium lead, and a fixed percentage is distributed to each of the partners based on the number of health zones and the agreed upon costs of the activities. CSOs send their financial reports and receipts to SANRU, which incorporates them into quarterly and annual reports. The CNP then sends the summarized CSO reports to GAVI.

For the CSO implementation, EPI indicators are being used as well as communication and other locally defined indicators. These are linked with the existing reporting systems and indicators that SANRU and the CSOs use as well as with the internal and external audits that are part of their projects.

Based on discussions and comments from stakeholders in DRC, the CSO grant is seen as the best-implemented GAVI grant. Stakeholders praised the transparency of the process of grants to

recipients, the burn rate of funds, and the reporting of activities and progress. Five members of the CSO grant are part of the ICC:

- Association des Rotary Clubs du Congo(ARCC) (Association of Rotary Clubs of DRC)
- SANRU/ECC (Rural Health Project, Christian Churches of Congo, administered with Inter-Church Medical Alliance)
- Catholic Relief Services(CRS)
- Conseil National des ONGs de la Santé(CNOS) (National Council of Health NGOs)
- Croix Rouge de la République Démocratique du Congo(CRDRC) (Red Cross of the DRC)

Injection Safety Grant

As noted in the September 2008 Annual Progress Report (APR), GAVI is urging the GoDRC to provide 50 percent of injection safety support, as agreed upon in previous APRs. Since the end of the Injection Safety funding by GAVI, the GoDRC has not taken up the funding of syringes or safety boxes. UNICEF is currently funding vaccines and supplies, a stop-gap measure that may continue until a permanent alternative, such as increased government budgeting and financing, is put into place. The 2008 APR (submitted in May 2009) specifically mentions that the traditional vaccines, the pentavelant share of the GoDRC, and injection supplies do not have government funding. The APR also mentions that BCG vaccines and injection supplies were out of stock at all levels in DRC in 2008.

New Vaccines Grant

All new vaccines were purchased (US $81 million) directly by GAVI from UNICEF/Copenhagen and forwarded to DRC. A first shipment of tetravalent was shipped to DRC in 2007 and a second in 2008. Pentavalent vaccine introduction began in 2009.

Nevertheless, the GoDRC is not meeting its financial share, as outlined in the gradual transfer of financial responsibility from GAVI to the GoDRC. GAVI's response to the DRC APR of 2007 clearly states that the agreement has not been respected. In addition, a line item for vaccines is still being worked out between the MoH and the Ministry of Finance.

Immunization Services Support (ISS) Grant

ISS funds are not part of the Ministry of Health budget and have been managed by the EPI Program. These funds are approved based on a yearly workplan submitted by the EPI program and approved by the ICC. Based on allegations and observations by stakeholders of suspected funds mismanagement by a former EPI Director and some EPI staff, the ICC recommended that an external audit be conducted. The audit, which was implemented by IFAF, a local accounting firm, for the period 2003 to 2005, identified the following:

- Lack of sound accounting system
- Non-existent budget-monitoring system
- Non-existent recording system for expenditures and receipts
- Deficient inventory (products and office supplies) system

ISS funds were used to finance most cold chain purchases from 2002, with the remaining funded by donors in their respective geographic zones. With the ISS grant ending in 2009, the EPI program manager has been advocating to the MoH to continue cold chain purchases through the regular MoH budget, but this has not occurred. As an alternative, during the 2009 HSS budget preparation, the EPI program requested US $5 million but received only US $1.5 million. There are no specific line items for EPI cold chain purchases in the HSS grant, but medical equipment purchases are identified. The cold chain equipment will be distributed to most health zones, with priority given to those where there is a gap between what is needed and what is available from other sources.

Overall EPI Financing Issues

The 2008 APR estimates that the financing gap of the DRC EPI is estimated at US $26.8 million in 2008. The APR also mentions that EPI partner (donors and NGOs) contributions cannot be correctly estimated, as there are no centralized donor fund mechanisms that allow proper monitoring of the funds provided. What is certain, however, is that the EPI Program is having difficulty raising national funding for the program, and it is only through stop-gap measures by UNICEF, WHO, SANRU and other donors that the EPI program continues to provide immunization services in many health zones. DR Congo is also struggling with the end of their ISS funds. This has resulted in operational problems for immunization service delivery and continued stagnating or falling coverage. Basically, DR Congo, as in many countries, have used ISS as a stop-gap, and/ has not had a plan for real sustainability. Even with the slow implementation of HSS, there are other factors that should be considered as the fundamental gaps in funding operational costs (outside of GAVI assistance) has not been really addressed in DR Congo.

a). Health care reforms and health systems strengthening efforts

DR Congo's national health policy goals include:

- Improving the supply and utilization of quality health services and ensuring the economic and financial sustainability of the DRC by 2009.
- Promoting maternal, newborn and child health in the DRC by 2009.
- Strengthening the prevention and management of epidemics in the DRC by 2009.

The National HSS strategy developed in 2007 outlines the systematic health care reform efforts to be undertaken by the MoH. The application for the GAVI HSS grant represented the first major effort to look at systemic HSS issues. However, many donors are implementing HSS strategies focused at the health zone level.

Health Systems

The DRC health system is decentralized, with primary and first referral services integrated in the health zones and each health zone serving a catchment population of approximately 110,000. In the 1980s, DRC was a leader in reforms that focused on integrated primary and first-referral services through the health zone model.

In 2001, the number of health zones was increased by the government from 306 to 515. Above the health zones, the administrative hierarchy involves provinces and the MoH central headquarters. The Government has also recently developed a strategy to convert the 11 administrative provinces to 26 regions, but this is not yet functional. The addition of the new health zones was primarily to increase geographic coverage of referral services, since each health zone is to have a referral hospital. Because of the lack of government financing over the last decade, the health zones and facilities operate with considerable autonomy, although MoH structures have retained administrative control, particularly over human resources. Many facilities became de facto privatized, relying on patient fees to pay staff and operating costs. However, recently, with improvements in MoH administration and funding, intermediate and central levels exercise more power. Estimates are that one third of facilities are operated by church groups, which have traditionally worked in partnership with MoH structures. This partnership has facilitated relationships between the MoH and NGOs for financing personnel and operating costs, particularly at the health zones level.

In the MoH itself, a restructuring process is underway to reduce the current 13 technical Directorates into 6. It is hoped that this will lead to better coordination and involvement between different Directorates and the various health programs within them. The restructuring process is expected to be rolled out in 2009.

Financing

Insufficient public spending over the past decade has led to the deterioration of the health system, leaving households and donors as the primary financiers of health services. In 2001, less than 1 percent of the Government budget went to the health sector. Since 2002, the Government Interim Poverty Reduction Strategy Paper (IPRSP) committed to allocate at least 15 percent of the national budget to the health sector. The proportion allocated to health in the Government budget has increased dramatically from less than 2 percent in 2002 to 7 percent in 2004.

Yet only a portion of these budgets have been executed. In 2004, estimated Government health spending was around US $25 million compared to the US $80 million budgeted. Equivalent to approximately US $40 per person, this level of domestic spending on health is among the lowest in the world. Increased external support (US $200 million annually expected in the coming years) could reach US $4 per capita annually, raising the per capita spending to US $16. The bulk of the resources from external sources will take the form of disease-specific support, raising the risk of continued verticalization of the system. In terms of resource allocation and management, there is a need to get health zones and provinces more fully involved in these decisions in order to develop their capacity and improve their ownership[11].

In the March 2008 DRC Public Expenditure Review, the DRC country budget was reported as US $2.46 billion, of which 4.1 percent was allocated to health. To date, however, the GoDRC has not been able to spend more than 57 percent of its health budget. The economic picture for DRC continues to worsen as the global economic downturn is directly impacting commodity prices such as copper and diamonds. Staggering numbers of miners are losing their jobs; the conflict in the eastern part of the country continues to consume scarce resources; and donors are forced to reprioritize resources[12].

Table 3: Overseas Development Assistance in Health in US Millions (current prices)

Item/year	2001	2002	2003	2004	2005	2006	2007
Health	1,706	2,436	2,668	3,369	3,448	4,463	4,339
General Health	712	1,066	1,099	1,403	1,310	1,674	1,308
Basic Health	993	1,370	1,569	1,925	2,138	2,789	3,031
Population Policy, Program and Reproductive Health	1,973	1,282	2,223	3,088	4,466	3,878	4,360

Source: ODA/OECD Database

b). Health system strengthening efforts by donors and other global health initiatives

Table 3 shows the more substantial donor-funded HSS activities in DRC. Based on this information, the GAVI HSS funds are the second largest HSS funds in DRC after those of the World Bank. Previous applications by DRC for Global Fund HSS support have not been successful.

[11] World Bank: Health, Nutrition & Population, DRC Country Status Report, 2005.
[12] DRC's Epidemiological Context and Health Indicators, USAID/Kinshasa, undated.

Table 4: Donor-funded HSS Activities in DRC

Donor	Amount in US$	Number of Years	Geographic Coverage
ASSNIP/Belgian Cooperation	$ 7.6 million	5 years (2005-2008)	No data
ASSNIPII /Belgian Cooperation	$ 11.4 million	4 years 2009-2013	5 districts
Candian International Development Agency	$ 8.6 million	7 years (2004-2010)	1 district
World Bank	$ 150.0 million	4 years (2006-2009)	83 districts
European Union	$ 100.0 million	4 years (2006-2009)	60 districts
USAID	$ 40.0 million	4 years (2006-2009)	60 districts
African Development Bank	$ 40.0 million	4 years (2006-2009)	26 districts

Source: *Interviews with donor organizations*

Donors are looking at the GAVI HSS mechanism and arrangements as a precursor to basket funding of the health sector. Donors and the CNP increasingly agree that large HSS projects, including large vertical projects such as the Global Fund for HIV/AIDS, Malaria and Tuberculosis, will need a different management mechanism than the current arrangement between the Country Coordinating Mechanism (CCM), Local Funding Agent (LFA), Principal Recipient (PR) and Sub Recipients (SRs). Round 8 of the Global Fund will include setting up a Project Management Unit (Cellule d'Appui et de Gestion [PMU]) within the MoH to facilitate the role of the MoH as PR. However, this PMU will still work with a separate fiduciary agent, who will manage and report on fund accounting to maintain good governance procedures.

Health Sector Coordinating Bodies

Donor coordination has significantly increased since 2002, but aid harmonization remains a challenge. Donors have traditionally funded vertical programs and created special mechanisms (administrative and fiduciary) to manage them.

The description, composition and specific roles of key institutions in the coordination of activities, as well as their role in the GAVI HSS processes, are described below:

Ministry of Health

The MoH, through the DEP, has overall responsibility for managing funds and activity implementation. Through DEP (see below), the MoH is also responsible for monitoring and ensuring the financial reports and budgets, with the Fiduciary Agent, and serves as the primary contact with GAVI.

DEP (Department of Research and Planning/Département d'Etudes et de Planification)

As the focal point for GAVI HSS, the DEP is the Technical Coordinator managing the program and serving as the Executive Secretariat of the National Steering Committee (CNP). The Executive Secretariat develops the annual report, which must be signed by the HSS signatories and submitted to GAVI at the beginning of the calendar (and fiscal for DRC) year. The centralized role that the DEP has played has resulted in some difficulties in sharing plans and coordinating implementation with other departments (such as the EPI, which was not closely involved in the proposal writing but was involved in the selection of the health zones) and other Directions (e.g., Primary Health Care and Disease Control and Surveillance). An HSS focal point was recruited by the DEP in July 2009, as requested by the CNP and donor partners.

The World Bank and EU, as well as other development partners, would prefer that a broader project management unit, rather than a single person, be put into place. The World Bank and others see a management unit as necessary to move the project along, and such a unit could potentially be expanded and institutionalized beyond the GAVI HSS funding. The management unit should track progress based on planning and an established time schedule, coordinate with partners and the CNP,

ensure reporting, manage contracts (in collaboration with the fiduciary agent) with NGOs that are receiving funds, and link with the partners receiving GAVI CSO funds.

CNP

A September 2006 Ministerial decree created the CNP and Comités Provinciaux de Pilotage - Provincial Steering Committees (CPP). As stated earlier, the CNP, with the DEP as Executive Secretariat, was instrumental in leading development of the GAVI HSS proposal.

The CNP was formed to support the GAVI application process and implementation. It is presided over by the Minister of Health and is in charge of coordination and decisions related to the proposal. The Inter-donor Health Group (Groupe Inter-Bailleurs Santé [GIBS]) is represented on the CNP through its (rotating) chairman and members. Within the CNP, there is an Ad Hoc Committee composed of a member of the Minister's Cabinet, the MoH Secretary General, the DEP, and a rotating member of the GIBS. The Ad Hoc Committee is in chare of relations with the fiduciary agent and overall management of the HSS funds.

The CNP meets at least once a month, with facilitation of meetings rotating between the different partner organizations. The central CNP is supported in the provinces by Provincial Steering Committees. According to the Ministerial decree that created them, Provincial Steering Committees are headed by the Provincial Medical Inspectors, who were already in place to manage overall provincial health services. During the field visits, the SPH identified discrepancies in the chairing of the CPPs, as some CPPs are headed by Provincial Governors and Provincial Ministers of Health.

Regardless of who is chairing, the CPPs have not yet actively participated in the GAVI HSS process nor made implementation decisions.

World Health Organization (WHO)

WHO introduced the GAVI HSS opportunity to DRC stakeholders and is a co-signatory with the DEP on the HSS account. The Ministry of Finance (MOF) allowed the opening of a DEP-managed bank account. All checks are counter-signed by WHO.

GARSS (Groupe d'Appui à la Stratégie de Renforcement du Système de Santé – Support Group for the HSS)

The decree also named the GARSS as the technical secretariat of the committee. In drafting the proposal, the GARSS [13] was formed from MoH, NGO, and partner staff and received technical assistance from the ICC and CNP. The GARSS is an informal group of the "internal diaspora": Congolese health experts working in institutions like WHO, UNICEF and health NGOs. It was first proposed and headed by the Belgian Embassy, with the GIBS (see below) now managing this through a rotating presidency. Since December 2008, the Canadian International Development Agency (CIDA) has chaired the GIBS. The GARSS' current role with GAVI HSS implementation beyond the proposal writing period is unclear.

Project Management Unit

This unit was created in August 2009 and staffed with personnel from within the MoH. Details of its composition and the funding are not available as of the writing of this report. The PMU will start managing large donor funds, such as the Global Fund and possibly GAVI. However, it is not yet known if or when the GAVI HSS management will be transferred from DEP to the PMU. The PMU will still need to use, at least in its early days, a fiduciary agent (see below) to disburse and account for funds.

Fiduciary Agent

The recruitment process of the fiduciary agent has been very slow and was not yet finalized by the end of July 2009. There was a competitive selection process managed by UNOPS, which sent the request for proposal and received the responses. The CNP, along with GIBS, made the final selection

[13] The GARSS' creation coincided with the start of the Global Fund applications in DRC.

of Audirex, a Cameroonian firm. However, as of July 2009, Audirex has not been granted a contract. The firm has been asked to provide additional financial data for the proposal.

The delay in recruiting the fiduciary agent (who is to be housed at the DEP) has resulted in the CNP setting up an interim management solution. While waiting for Audirex to settle in DRC and open its offices in Kinshasa and the selected health zones and provinces, GTZ was selected as a temporary fiduciary agent, with a renewable three-month contract. It is expected that GTZ will manage the first tranche of funding going to the 65 health zones, once their proposals have been approved by the CNP. A first tranche of funding was wired to the GTZ German account in early March 2009, and the money was transferred into the GTZ DRC account around the same time. During the 31 July Country Case Study workshop, GTZ noted that they had not received information on the decision to hire Audirex (GTZ was one of the agencies which submitted a proposal). All communications between DEP and the fiduciary agent will be copied to the CNP Ad Hoc Committee.

The fiduciary agent financial management mandate is as follows:

- Cost the action plan and prepare expenditure projections.
- Verify unit costs of the action plan and the various provincial and health zones proposals elaborated and coordinated by DEP.
- Procure equipment for a maximum of US $30,000 per unit.
- Act as the payer to executors for all activities validated by the DEP action plan.
- Provide regular expenditure statements at all levels (central, provincial and health zones) to the DEP.
- Build the capacity of MoH staff for expenditure management and reporting.

It is envisioned that the fiduciary agent may need to create provincial structures to facilitate field payment and receipts collection, as well as to verify work. Setting up the fiduciary agent structures to enable the agent to be an effective player in the implementation process will most likely take additional time and may further slow the implementation process.

GIBS and Donors/Development Partners

As part of the GIBS, donor and development partners contribute to the piloting and monitoring and evaluation of the HSS “program” through the CNP Ad Hoc Committee for the approval of annual plans and expenditure planning and financial reports and Initiate technical and financial audits through the CNP.

National and International NGOs (Technical Implementers)

DRC has a long history of NGOs and donor at all levels providing financial, logistical and technical implementation assistance. Technical implementers are defined as those who provide technical support to the teams working in the health zones (e.g., both the general reference hospitals and the health centers) to undertake their service delivery tasks. Technical implementers are contracted by either the CNP or the CPPs.

The document defines the roles of the technical implementers as the following:

- Providing technical validation of the activities financed by GAVI HSS.
- Evaluating performance contracts and the quality of services provided.
- Serving as pass-through mechanisms for funding and equipment to the health zones structures.

V. GAVI HSS Proposal Development and Application Process

a). Chronology of the GAVI HSS application

The HSS process in DRC began in late 2005, with the GAVI HSS application, approval and disbursement process started in 2006 and culminating in the first disbursement in March 2008. Whereas WHO introduced DRC to the GAVI HSS opportunity, the DRC's MoH, with the help of the GARSS, took the lead in the discussion and proposal writing processes.

The GAVI HSS application process is outlined below within the context and timeline leading to the development of the national HSS plan.

Table 5: Steps leading to GAVI HSS grant in DR Congo.

December 2005	Meeting of stakeholders on HSS for DRC
February 2006	Annual review of the Ministry of Health programs GIBS declaration highlighting intent of donors to fund HSS components in all health activities Proposal by the MoH for the creation of a group of national health experts, to be supported by international organizations and experts, to prepare the HSS proposal to GAVI
May 2006	First meeting with WHO/Geneva and WHO/AFRO on procedures for the GAVI HSS application Proposal preparation begins
June 2006	National HSS plan developed by the MoH Secretariat and partners
September 2006	Ministerial decree for the creation of the CNP and CPP
October 2006	2007 – 2009 Interim National HSS Plan elaborated Roles of CNP, CPPs and GARSS outlined by the Ministry of Health decree Official start of CNP
November 2006	HSS proposal sent to GAVI by DRC GAVI communication to DRC of "conditional approval" Comments from the World Bank on the DRC proposal sent to GAVI[14]
February 2007	Resubmission of proposal to GAVI
March 2007	DRC response to questions from the GAVI Internal Review Committee
December 2007	Notification to DRC by GAVI that the HSS proposal was approved and would be funded Memorandum of Understanding developed on the implementation modalities for the GAVI HSS funding.[15] This memorandum, signed by different parties in December 2007, describes the involvement and

[14] Due to timing discrepancies, the World Bank memo on proposal comments was sent directly to GAVI without discussion first with the MoH, the DEP and GIBS, which caused some concerns among the partners.

[15] Document name: Memorandum d'Entente sur les Modalités Pratiques d'Exécution de la Proposition HSS-GAVI/DRC

	management roles of the different agencies (CNP, DEP, WHO, GIBS, the fiduciary agent, the CPPs) for the GAVI grant.
February 2008	First allocation of HSS funds received

Nature and Level of Technical Assistance Received during the Process

The proposal preparation process was designed at the national level, with the DEP in charge of the process and development of the document. During the health annual review in April 2006, WHO/Geneva alerted the MoH and stakeholders of GAVI's new HSS financing window.

Although there was no specific technical assistance for the application development itself, support was provided by the WHO (Headquarters and the AFRO regional office and its Inter-Country Support team) and the DRC office. WHO /AFRO assisted in explaining how the HSS funding differed from previous GAVI financing. It also assisted with input for the proposal as well as the response to the conditions, in partnership with the Government (including MoH, MoF, MoB) and the bilateral partners. These partners—including UNICEF, USAID, the World Bank, Belgian Technical Cooperation, SANRU, and Rotary—were also given the draft for feedback. However, despite detailed comments from partners (e.g., the World Bank), significant changes were not made.

The DEP and its partners used existing data (e.g., coverage data and population density) to determine which health zones were the weakest in terms of bringing down the immunization coverage average. 100 health zones were identified and then prioritized based on those with no support, those with partial funding, and those with the potential for demonstrating impact given their past performance. This resulted in the selection of the 65 health zones outlined in the proposal. The health zones were not involved in the initial development of the proposal but are now involved in the micro-planning for HSS.

CSOs and their funding for health zones were mapped and taken into account in the proposal. SANRU (through its USAID-funded AXxes project)[16] was involved in the proposal development and has a representative on the Secretariat. One constraint in the mapping was that the type of support donors were giving and established criteria for what donors should be providing were not well outlined in the proposal. For the CSO window of support, the various CSOs already working in the 65 health zones were considered. SANRU, CRS, and Rotary, who have traditionally been involved with EPI support, were part of the initial proposal development and contacted other CSOs (e.g., MedAir, Red Cross, and the National Committee of NGOs) to participate in the implementation.

The DEP did the initial costing for the proposal on behalf of the CNP. For the Human Resources section, the costing data used were generated by the Direction of Human Resources with the assistance of the Belgian Technical Cooperation. SANRU provided them with information on the "kit de base" (e.g., laboratory, equipment, medical supplies) needed for a functional health zone, which was used as cost criteria for the non-supported health zones.

b). Stakeholder perceptions

Satisfaction/Dissatisfaction with the Planning Process and the Resulting HSS Application

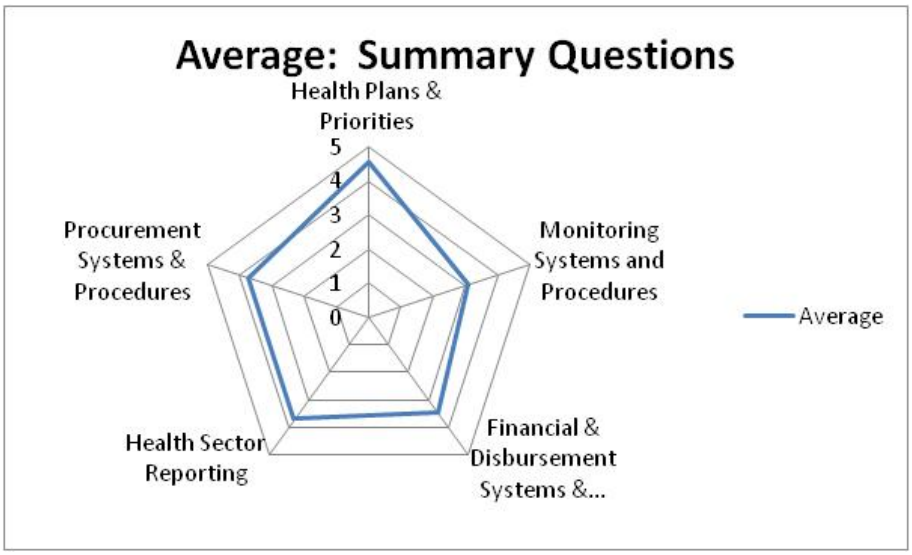
There was overall satisfaction with the proposal development/application process. The proposal used the national HSS strategy, and partners felt that the HSS proposal was embedded in the HSS

[16] AXxes is a USAID supported 4 year, US$ 40 million USAID-funded This project will contribute to achieve the whose objective is to 'Increase access to essential services provided by local and national institutions". At the end of the project, USAID expects to have assisted the GDRC in (1) providing essential health care services to an estimated 8,000,000 people; (2) improving the management of the health zone and referral system; (3) improving the capacity of provincial and district health offices to assure provincial/district level coordination and supervision; and 4) improving the capacity of several local NGOs through small grants program to advance their management systems and their ability to provide quality health services

dialogue. The MoH and DEP did not restrict the process to just the MoH; rather, they used a participatory approach involving GARSS and GIBS. GARSS and GIBS members were satisfied with the level of information gathering and the CPN interaction with them in the planning/proposal preparation process.

Nonetheless, the proposal may have been attempting to address too many elements[17]. For instance, elements of the HMIS were included as part of the monitoring and evaluation systems and a number of HMIS indicators were to be used. But this study found that a number of the indicators were not operational. As a result, JSI, through a sub-contract with the SPH, worked with the DEP and HMIS to design and operationalize a tracking tool.

Negative comments about the planning process came from other MoH departments and donors, who felt that the implementation stages were not clearly identified in the proposal, notably the issue of the "size" of the mandate of a fiduciary management structure. Another concern from departments within the MoH was that the proposal development process was not sufficiently participatory (although the ICC was involved). Interviews revealed that other MoH departments were consulted, but the process seems to have been ad hoc.



The spider-diagram above was developed on a 0-5 grading system for each component. The responses were from 19 stakeholders interviewed in December 2008. Additional interviews conducted in March and July 2009 confirmed the results of this spider diagram. The components were determined to capture stakeholders' views on how the GAVI HSS-funded activities were aligned with national priorities and systems:

- **Health Plans and Priorities** (Score 4.55) - This area received a high score, reflecting stakeholders' views that the GAVI HSS proposal is based on the National HSS Strategy.

- **Procurement Systems and Procedures** (Score 3.71) - Stakeholders perceived that the system put in place by the GAVI proposal reflects a summary of systems and procedures implemented for donor-funded (vertical) programs. It should be noted that the GAVI proposal bypassed the GoDRC systems and procedures, as these will be managed by the CNP and its Ad Hoc Committee.

[17] The World Bank made it clear that the geographic reach of the proposal was too broad and that the resulting impact from the diluted funding may not materialize.

- **Health Sector Reporting** (Score 3.71) - Stakeholders noted that they were more concerned with the difficulty and imprecision of the national reporting system itself than with the HSS alignment with national priorities and systems.

- **Financial & Disbursement Systems & Procedures** (Score 3.5) - Stakeholders reported that, similar to Procurement Systems and Procedures, the GAVI proposal reflects a summary of donors' requirements, not national procedures.

- **Monitoring Systems & Procedures** (Score 3.1) - This lowest score reflects stakeholders' acknowledgment that the indicators to be reported for HSS may be difficult to obtain due to the weakness of the system. But overall, they believe that the indicators reflect those proposed in the Health Interim Plan 2007-2009.

Suggestions for improving the proposal development/application process

GAVI should suggest that a financial management system be identified from the onset and that a structure be in place prior to receipt and disbursement of funding. A possible extension of this would be for GAVI to request that countries provide a timeline in the proposal, outlining the steps to be taken to institutionalize the management process.

The GoDRC was able to garner existing resources in the proposal-preparation phase—primarily locally through the GARSS and from WHO. However, additional assistance would have been beneficial for the design and outline of a mechanism to provide funds to the health zones. It is only in late 2008 that such a mechanism was finally agreed upon, with the process for providing funds to health zones started in March 2009.

VI. Content and Characteristics of the GAVI/HSS Application

a). Description of GAVI/ HSS approach

Primary Themes/Objectives and Key Activities

The National HSS Strategic Plan was used, and the GAVI HSS proposal will help to initiate MoH HSS support in targeted provinces and health zones.

The axes of the GAVI HSS strategy are the following:

1. **The organization and implementation of the strategy for the revitalization and development of health zones, namely:**
   - Provide organizational support for the provinces at the central and intermediate level
   - Draw up standards for the organization and operations of the central and intermediate levels and thus improve information management
   - Conduct a baseline assessment of indicators of the health situation and level of performance of health structures
   - Establish a basket-funding system for the provinces that are to receive GAVI support
   - Improve the supply of essential medicines and specific inputs to improve the quality of care in the chosen health zones
   - Conduct annual reviews of the sector at the central and intermediate levels
   - Invest in vehicles and computers for the CNP and CPP
   - Implement the revitalization of 65 health zones
   - Support the operations of the general reference hospitals
   - Extend health coverage of the health zones through a working capital for supplies of medicines for regional drug warehouses
   - Support supervision by Health Zone Executive Teams (e.g., vehicles for transportation)
   - Improve water sources to increase community level support
2. **Human Resources, namely:**
   - Develop a policy and policy measures for human resources
   - Support educational reform in the health sciences (training of certified nurses)
   - Strengthen the capacity of the Provincial Executive Teams
   - Train and retrain nursing staff at health centers and the general referral hospitals
   - Establish a Monitoring Center for Human Resources and the Health System
   - Establish direct interventions for human resources in the 65 health zones
   - Improve the salaries and supplements for health staff

In addition, GAVI support will contribute to the implementation and strengthening of research on the health system, including documentation and assessment of the process and effects of the support towards improving knowledge and capacity to manage changes.

Budget Allocation

Table 6 shows how DRC presented the proposal budget to GAVI in 2006.

Table 6: GAVI HSS Budget Proposal, in US$ Millions

Support to Service Delivery	**41.4**
TA, Training, Superv/Admin costs (health zones & Hosp Mgmt)	3.7
Regional Drug Warehouse/Drugs Supply	9.2
Health Facility Infrastructure & Equipment	13.1
Health Workers Incentives	14.3
Training of Health Workers	0.9
Community Water Supply	0.2
Health Admin, Institutional Dev, TA & Project Management	**15.4**
TA & Training to Central Health Administration	2.1
TA & Training to Provincial Health Administrations	3.2
General TA & Assessments	2.6
Project Management Costs	7.4
TOTAL	**56.8**

Approximately 73 percent of the proposed funds are to go for front line providers and drugs, equipment, and infrastructure at the primary level, with the remainder for the central level and project management costs. The activities funded are to have a direct impact on service delivery at the periphery level. The funding focuses on the 65 health zones and improving the capacity of the three provinces through worker incentives (including at the central level), infrastructure, equipment and drugs supplies. Incentive systems are expected to assist in strengthening services at the health zones level, based on past donor support for health zones (which needs to be continued and integrated with health reform to be sustainable).

The World Bank presented the budget in another format (see Table 7).

Table 7: Functional Breakdown of GAVI's HSS Budget

	US$ Million	**Percentage**
Infrastructure	5.9	10%
Equipment	8.6	15%
Drugs	9.1	16%
Health Workers Incentives	14.3	25%
Consultants & Studies	3.5	6%
Training & Study Tours	2.2	4%
Operations & Overhead	13.2	23%
TOTAL	**56.8**	**100%**

Source: *WB/DRC 2006 Comments on the RDC HSS Proposal to GAVI*

There is also a fairly substantive amount of operations costs and overhead (23 percent) in the proposal. The World Bank argued that this amount is excessive and suggested that it should be reduced, as it is not tied directly to service delivery.

Relationship of themes/activities chosen to past assessment findings and recommendations

The selection of health zones was based on coverage, past and current support to these health zones, and previous experience with health support and the minimum package of support needed to strengthen health zones (e.g., SANRU experience). Prior to the GAVI HSS proposal, the MoH, with the support of GARSS, produced the national Health System Strengthening Strategy (HSSS) in June 2006, whose principal focus is the revitalization of the health zones and is similar to the focus of the GAVI HSS proposal. The GAVI HSS proposal is therefore to integrate with the national health planning strategies and address bottlenecks in the system to enable increased coverage with health services. WHO[18] played a role in explaining the linkage of the HSS with the health sector, including but not limited to EPI. Despite detailed planning, there have been challenges in linking the GAVI HSS with the EPI plan as well as comprehensively addressing the broad health system issues.

b). GAVI HSS implementation

The HSS funding will follow the "Health Zone Development Plans," towards assisting with the *minimum package* of needs for HSS support in the health zones. This will be managed by the DEP and CNP, in partnership with the health zone Medical Heads, Health Inspectors (at the provincial level), and partners in the health zones, with support from the provincial level. In March 2009, the DEP, after a stakeholders meeting that included provinces and selected health zones, launched a request to NGOs to submit proposals for HSS funding. The plans are to be submitted to the DEP and then reviewed by the CNP. The turnaround time was short, however, with the RFP issue date in early March 2009[19] and submissions to be received by July. As of July 2009, over 50 health zones responses had been received, with the following status:

- 40 health zones that had sent their development plans.
- 13 more health zones that had reported that their proposals would be submitted late.
- 12 health zones whose status needed additional discussion. During the proposal preparation, these health zones were selected because of the existence of "complementary" partners. However, since the proposal approval, the partners had moved out of the health zones.

As of July 2009, the process of approving the health zones development plans and negotiating the requested budgets had not been initiated, and the timeline for forwarding these funds to the health zones has not been communicated. A formal review process by the CNP of the 65 proposals had not begun. In addition, the situation analysis that the SPH has been tasked to do as part of the initial HSS activities had not yet started due to the delayed release of funds. The analysis was to be launched in July 2009, and the report is expected by the end of 2009; it is to provide information for the health zones to assist them in developing their plans.

In addition to the health zones, three provinces were identified in the HSS proposal for support: Kinshasa, Bas-Congo, and South Kivu. These provinces were selected based on immunization coverage data and past performance. They do not have partner support and are considered capable, with some additional assistance, of supervising and ensuring HSS implementation in their health zones.[20]

[18] WHO advocacy for HSS started in 2000 as a way to meet MDGs.

[19] Although the document is dated 16 January 2009.

[20] The 65 health zones selected for GAVI HSS support are not located in these provinces, as it is assumed that the health zones in these provinces are better performing. Therefore, it is anticipated that this support at the provincial level will extend the HSS impact through improvements in management and supervision.

Although the DEP did the final costing for the proposal, prior assessments were used in the costing analysis. For the Human Resources section, for example, the costing data came from data generated by the Direction of Human Resources (1ère Direction) from work on human resources conducted by the Belgian Technical Cooperation. Also, SANRU provided the DEP with information on the "kit de base" (laboratory, equipment and medical supplies) needed for a functional health zone, which was used as the cost criteria for the non-supported health zones.

Disbursement of GAVI HSS Grant

Table 8: Dates and Amounts of HSS Funds Sent by GAVI to the DRC

Country		Date of Submis-sions	Date of proposal or monitoring recommendation	Date of board approval	Date of wiring funds or WB release	2007	2008	2009	2010	Total
DR Congo	Committed (approved proposal)	3/2/2007	20/42007	5/12/2007		$21,526,000	$15,717,500	$11910,000	$7,661,000	$56,814,500
	Disbursed				8/2/2008		$21,526,000			$21,526,000
	Disbursed				28/4/2008		$20,139,500			$20,139,500
	Still to be disbursed							$7,488,000	$7,661,000	$15,149,000

The data in the table above show that over US $41 million has been provided to DRC. The first tranche of US $21.5 was submitted nine months after the GAVI Board gave its approval, and the second tranche of US $20.1 million was sent a short time afterwards. As the table indicates, the amount remaining from GAVI for DRC is US $15.1 million, to be sent in two tranches in 2009 and 2010.

Management and financial arrangements proposed

As noted previously, WHO is assisting with the technical and financial management of the HSS funding and is co-signatory with the DEP on the bank account opened by the MoH for the GAVI HSS funds, with authorization on the account by the DEP co-signed with WHO. An MOU ("Memorandum D'Entente Sur les Modalités Pratique d'Execution de la Proposition RSS/GAVI/RDC") was drafted in December 2007 between WHO, UNICEF, the Government and GIBS to outline the process of authorization, distribution and accounting for funds.

As the Technical Secretariat, the DEP develops a quarterly action plan that is submitted to the CNP and then to GIBS for approval. Once approved, the funds are then authorized for disbursement.

An independent fiduciary agent is being contracted to work with the DEP for the collection of financial reports and receipts. Selection among five short-listed candidates was finalized by the CNP, and the recruitment was completed by January 2009. GTZ is serving as an interim fiduciary agent while the long-term mechanism is put into place. The United Nations Office of Project Services (UNOPS) was selected to handle the grouped procurement of vehicles and computer equipment, and UNICEF was selected to handle the medical equipment.

As of December 2008, a total of only US $108,520[21] has been spent. The following table (provided by DEP as projected expenditures up to June 2009) shows expected expenditures by July 2009[22].

[21] **Source:** APR 2009 Report.
[22] Data in table provided by DEP.

Table 9: Expenditures Expected by July 2009

Vehicles purchase	1,797,000
Computers/associated equipment	215,000
Meetings costs	35,894
DEP building construction/extension	200,00
Medical equipment	6,149,800
Short-term technical assistance	150,000
Annual review	100,000
HSS Project launching workshop	70,000
Situation analysis study	706,060
Total	9,423,754
Management costs	1,413,563
Grand Total	**10,837,317**

Source: DEP

Based on discussions with DEP, expenditures are expected to reach US $14 million by the end of 2009.

Audit procedures are outlined in the proposal but have not yet been put into place. It is anticipated that this will be part of further discussions when the fiduciary agent is selected and operational.

c). Monitoring and evaluation plan

Key indicators, targets and processes

Monitoring of the indicators in the DRC proposal is to be entrusted to the Monitoring Center within Health Systems and Human Resources in the MoH. In discussion with the HR Division and the HMIS, it does not appear that such a Center is yet operational. In Phase II of the tracking study, the SPH assisted with outlining tracking for the HSS indicators. The proposal also specifies a yearly external audit (by consultants, WHO or/and universities) and quarterly audits, which have not yet begun.

The monitoring tools and base indicators were selected from among those provided in the Interim 2007–2009 HSS Plan (IP -07-09). By comparing the IP 07-09 indicators for all health zones with those of the target health zones, it will be possible to monitor the impact of the GAVI HSS funding. In addition, a number of indicators will be measured within the framework of other studies to be carried out (e.g., the Demographic and Health Survey, the data of which will be broken down per province). The HSS tracking study has also helped to guide the process for HSS indicator monitoring through the SPH technical assistance.

Indicators

The table below lists the proposed HSS indicators, which are a mix of process (financing, planning and implementation processes) as well as output and outcome indicators. HSS support was granted in 2007, with April 2008 marking the start of the implementation period. Data from 2008 will be considered as baseline and will be used to determine the allocation of 2009 funding. The 2008 DHS data will also be considered.

As part of the Tracking Study, the SPH assisted in identifying a list of indicators to monitor the HSS implementation process. The suggested indicators correspond with the key activities and steps of the HSS implementation and are organized under the headings of implementation of the health zone

Development Plans, functioning of the CPP (including supervision), health zones development, and human resource development (see Annex 5).

Table 10 Indicators for HSS Monitoring, DRC Country Proposal.

	Indicator(s)	Data source(s)
HSS contributions	Rates of budget execution of the financing allocated to the health zones	Annual reports of the National Health Information System
HSS activities (3 main)		
Put the provincial steering committees (PSCs) into operation	Proportion of provinces with an operational PSC	Annual reports of the National Health Information System Reports of the annual national and provincial reviews
Draw up the health development plans of the health zones supported	Proportion of target HZs with a health development plan for the HZ	Annual reports of the National Health Information System Reports of the annual national and provincial reviews
Develop/revitalize the health zones	Number of operational health zones in the target provinces	Annual reports of the National Health Information System Reports of the annual national and provincial reviews
Outputs (impact on the capacity of the system)		
	Health coverage in the target geographical area	Reports of the annual provincial reviews
	Number of provinces with an operational basket-funding system	Reports of the provinces to the national annual review of the health system
Impact on immunization	• DTP3 • Routine measles	EPI reporting system plus ad hoc surveys Information System IP 07-09 Demographic and health survey scheduled for 2007 and 2012 Sampling at provincial level
Impact on child mortality	• Mortality of children under the age of 5	Report of the demographic and health survey scheduled for 2007 and 2012 Sampling at provincial level

Appropriateness of plan

The proposal includes US $240,000 that has been allocated for monitoring, evaluation, and audit activities. The World Bank raised concerns about the inadequacy of these funds for such a large task. Discussions with the Disease Control and Surveillance Unit and the HMIS unit revealed that there is a need to integrate surveillance and M&E data, as these have been largely verticalized to meet program-specific needs. Based on information from the HMIS, there is an indicator framework (financed by the EU and implemented by CREDES/France) that was made official in 2005 by Ministerial decree. Although this framework is not mentioned in the GAVI proposal and is not yet operational for the health zones, it has been applied to the provinces.

Monitoring the incentive payments to health staff and the impact of these towards achieving HSS targets will be a challenge and priority for the CNP. An initial agreement was reached among partners for standardizing the incentive payments and using these as supplements to make up for lacking

funds. This step is based on work done by the Belgian Technical Cooperation and the Ministry of Health Human Resources Division. However, there is no operational plan for the incentives, and, more importantly, more discussions are needed on how to link payments with demonstrated impact and results. Sustainability—i.e., ensuring that these funding levels can be continued after the HSS funding ends—is also a concern.

d). Attention to Paris Declaration and other GAVI HSS principles

Alignment

The GAVI HSS funding is aligned with the national HSS plan, whose major components are represented in the GAVI/HSS-funded activities. The challenge for the HSS is that it is currently being run like a program and not a project. It needs to be better integrated within the health reform process and involve the various MoH Directions for ownership and sustainability. The linkage of the financial incentives with performance, for example, should be ensured with the various health Directorates that manage health staff. It also needs to be understood that the HSS funding is supplemental and complementary to what needs to be ensured in the long term through the country's financing. Performance contracts are also to be part of this process, including guidance on the minimum package of activities to be implemented and how these are coordinated and evaluated.

As noted previously, a situation analysis is planned as part of the HSS proposal and is to be implemented by the SPH. This has been delayed, however, and is expected by the end of 2009. It will be conducted in all provinces and health zones throughout the country—including those targeted by the HSS—and will look at human resources, equipment inventories, and health structures in the health zones and the general reference hospitals (at the provincial levels). The DEP is preparing the budget for this by province. The study was launched in July 2009.

Links to Immunization

Immunization coverage (DPT3 and measles) is considered to be a key indicator for the HSS. The immunization program in DRC has served as part of the base for primary health care services since it was established in the country. Since 1998, it has been a lead program in the country, as DRC has been recovering from the crises of the late 1980s and 1990s. The HSS plan also addresses other indicators and health programs (e.g., IMCI, safe newborn delivery, nutrition) as part of the minimum package of services that should be provided and assured at the health zones level. The EPI monitoring mechanisms are in place, and reports are being received and tracked. The challenge, however, is ensuring the quality and reliability of data and completeness of reports, for EPI as well as for the reporting of combined health indicators. This process is more sustainable in the supported health zones than in the non-supported ones.

Harmonization

The HSS indicators relate to the available data from administrative reports and follow the overall monitoring process in the DRC health system. Sub-indicators are needed with the HSS, for example, for supervision visits and to further define how functionality of the health zones will be measured. At the health zone level, monthly meetings are held to review data, as this is a directive of the MoH for the health zones. As noted previously, to support the use of the available HMIS data, the proposal allocated US $240,000 for support to the national HIS, but the adequacy of this amount was questioned by the World Bank and the HMIS itself.

The EPI program has expressed concern that they were not adequately involved in the proposal preparation and has proposed that HSS activities reflect the micro-plans coming out of the health zones, which include immunization.

Stakeholders agree that there is not yet a uniform, national system for financial management. The MoH does not have a permanent Direction of Finance and Administration (F&A), and donors have set

up separate financial management units, which differ from one donor to another. For the HSS funds, the Ministry of Health and its partners agreed to a new type of financial management system through a fiduciary agency, which is currently being recruited. At present, the future of this management system is not assured beyond the GAVI HSS funding period. The MoH and donor partners would like to have a more permanent system that could evolve into a permanent financial and administrative unit within the MoH. Such a system could begin through HSS implementation, but would need to be fostered and closely monitored.

For the salary supplement payments, the proposal reflects a year-long consultation on this issue. A decision was agreed to, in line with the Mbudi Accords[23], by the MoH and GIBS to provide salary supplements as part of the "social contract" necessary to ensure sufficient remuneration to health staff.

Complementarity

Except for 10 health zones[24], GAVI funding will complement funding from other donors: UNICEF, USAID's AXxes project (through SANRU), EU, USAID, Belgian Cooperation, Doctors of the World, CRS, and others who provide support to specific health zones. The health zones were selected for the HSS with the aim of either (a) improving the performance of weaker health zones in terms of health services or (b) maintaining the health zones' performance at their existing levels (e.g., where a partner who had been giving support has stopped doing so). The health zones were selected mostly in the provinces with low immunization coverage on the basis of the following criteria:

- Immunization coverage,
- Development potential,
- Existing or forecast level of support, and
- Performance of the reference general hospital in support of decentralized health structures.

These criteria resulted in the selection of the following 65 health zones:

- 40 health zones that will receive their funding from GAVI only,
- 6 health zones with no provision for financial support but good potential for development,
- 10 health zones that will have had their external aid phased out in 2007 but have high potential for development, and
- 9 health zones whose GAVI support will focus on the general reference hospitals.

The World Bank analysis of the HSS GAVI funding going to health zones suggests that per capita expenditure would be $3.50/year—an amount consistent with the level desired by other World Bank projects—and the HSS funding will contribute directly to raising the number of health zones that receive this amount from 130 to 195 (out of a total of 515). However, the World Bank is concerned that this amount may not be reached if other donor funding or additional Government commitment is not secured.

Donors provide annual projections on needs at the health zones level, which are to be taken into consideration when determining and disbursing the HSS funds. At the end of the calendar year, the partners begin this planning process to ensure that funds projected are going to be available. Funding is usually fixed by February.

[23] The Mbudi accord was negotiated in 2004 between the transitional government and public administration union, seeking to improve salary scales for public administration positions. The government promised to progressively implement the scale in 2006 but has still not been implemented by the government.
[24] Annex 33 of the proposal.

Sustainability

The GAVI HSS funds are to be used as a launching point for health funding, accountability and sustainability in the MoH, with a goal of increasing government allocation to health in the GoDRC budget.

As a first step, the MOF and Ministry of Budget participated in the 2008 annual immunization review, and they are working to ensure funding for a vaccine line item in the budget. GoDRC funding for a vaccine line item was not committed in 2009, however, and the GoDRC continues to rely on UNICEF as the provider of vaccines for the country. This process is an ongoing priority and will also be used to advocate for additional funding for health in the overall government budget. If greater Government commitment for health spending is achieved, for example, as evidenced by a vaccine line item, then additional funding from donors will potentially be organized through similar structures and mechanisms, along the lines of a basket funding approach.

Stakeholders are concerned that the funding of activities implemented by the HSS funds may not be taken up by the GoDRC upon the end of GAVI support. The current total health spending is inadequate, in large part due to the war funding which may not make it possible for the GoDRC to implement the Abuja Declaration (i.e., 15 percent of Government budget going to social sectors). This not only applies to HSS but also to other GAVI funding. Injection safety, for example, is still funded by UNICEF, and there is still not a line item in the budget for vaccines. GAVI is also currently funding the new vaccine introduction.

If the current financial management structure (with the fiduciary agent) being set up to manage the flow to and accounting of expenses from implementing organizations is not institutionalized, then it will most likely not exist past the end of the GAVI HSS funding.

VII. Country Performance Against Plans and Targets

a). Implementation experience/absorptive capacity

Management and Coordination Mechanisms

The August 2007 "Management Mechanisms of the GAVI HSS Fund" document developed by the DRC partnership defines the management mechanisms and procedures, including roles and responsibilities for the CNP and the CPP (which were created by two 2006 Ministerial decrees). In addition, it describes the legal framework and the respective roles of the public, private and international partners in the GAVI HSS funding implementation. One inconsistency, however, is that although the MOF is mentioned in the August 2007 document, it does not appear to have a major role in the implementation process.

- The Paris Declaration and other core GAVI principles: Due to the delay in HSS implementation, it is difficult to determine at this stage if the Paris Declaration and GAVI HSS principles are being implemented. However, the GoDRC proposal addresses adherence to the Paris Declaration, and it is anticipated that implementation will follow what is outlined in the proposal.

- Financial management, financial procedures and flow of funds: Although the GoDRC and donors are focusing on the establishment of a proper financial management system to ensure that the flow of funds is transparent and accountable, the time it has taken to set up these mechanisms has slowed implementation and resulted in an extremely low burn rate.

- Flow of funds and common bottlenecks: As noted, the delay in fund disbursement for HSS implementation is due essentially to the delay in the selection of a proper fund management and disbursement mechanism. This is a new process compared to previous fund disbursement through donor-funded vertical programs. The burn rate for the CSO grant funding, however, has been quite satisfactory, and activities are being implemented according to plan.

Once disbursement plans are drawn up by the CNP and the Ad Hoc Committee, funding to technical executors by the fiduciary agent should go smoothly. However, this also necessitates that the fiduciary agent is available, which is currently being worked on.

Based on past experience, stakeholders note that obtaining all receipts from local executors may be difficult and will, therefore, require a very good system and management by the fiduciary agent. This is more of an expenditure reconciliation and financial accounting and management issue than a disbursement bottleneck.

- GAVI HSS allocation/spending compared to plan: Until December 2008, expenditures amounted to just over $100,000, and just over US $10 million (cumulative), and US $14 million (cumulative) is expected to be spent by July 2009 and the end of 2009, respectively.. But no funding has reached the health zones, and none of the "education" activities have received any funding or have started. These delays reflect the lack of a financial management structure for the GAVI HSS funding. Stakeholders have requested details from the DEP on the balance of the first tranche of HSS funding received.

Attention to financial sustainability

Due to the delayed implementation, systematic attention to financial sustainability is not yet in place. The proposal and donor strategy for financial sustainability is based on "economic growth" and an eventual increase in public revenues and Government commitment, based on the Abuja and Mbudi accords for increased public expenditures.

Salary supplements are a particular concern for sustainability. Generally viewed as a way to adjust for very low salaries in the public sector, these salary supplements are implemented in various ways and differing amounts by donors. Although civil service reform to address this issue has been discussed, it is far from being enacted. The reform needs to offer a long-term solution for increased salary payments that corresponds with the salary supplements paid in the past by donors and that are included in the HSS.

b). Monitoring and Evaluation Practices

- Indicators, information systems, procedures at each administrative level: With the implementation delay, monitoring and evaluation practices cannot yet be evaluated. The SPH findings show that a number of indicators need to be further developed. As part of this study, the SPH designed a tracking tool (Annex 5) which the DEP and HMIS can use for HSS monitoring. Immunization data are being monitored and reported routinely. Given the delay in HSS implementation, however, the contribution of HSS efforts to improved immunization coverage and reduced child mortality cannot be determined.

- Use of monitoring data for planning or policy making: The HSS proposal was based on existing data and outlined indicators to be tracked. Therefore, it is anticipated that data will continue to be used for monitoring implementation. The DEP has staff and experience in doing research and using data, in collaboration with the MoH HMIS unit. The DEP is about to start a National Health Account (NHA) exercise with Abt Associates, which illustrates its understanding of the possible use of data and will help to inform planning and policy making.

- Capacity to monitor and report on GAVI HSS performance: The original framework and list of indicators for HSS performance monitoring and reporting included existing indicators. The additional needed indicators outlined in the tool developed by the SPH should help improve the capacity to monitor and report on HSS performance.

VIII. Conclusions

There are several key factors—both positive and negative—affecting the country's HSS performance.

a). GAVI HSS Proposal Development and Application Process

The proposal development process was fairly well coordinated and included Government and donor input. Some departments within the MoH did not feel that they were adequately consulted, which is being addressed as the implementation process moves forward. The process development was based on past experience with health proposals and engaged the CNP for coordination.

b). Strengths/Weaknesses of the HSS Application

There were several strengths in the HSS application process:

- There was an existing national HSS strategy that significantly informed the GAVI HSS proposal.
- Extensive consultative support was provided by the "diaspora" group.
- There was donor commitment and coordination and experience from other GAVI, Global Fund and World Bank proposals that contributed to moving the proposal drafting process forward quickly.

The main weakness of the application process is that it did not consider the complexities of financial management that would need to be in place to rapidly coordinate and disburse funds. The initial assumption was that the National and Provincial Steering Committees would open and operate separate accounts for the management of GAVI funds and that the accounts would have two signatories at each level. The CNP account was to be managed (at least for check signing) by the DEP Director and the Coordinator of the NSC Technical Secretariat (WHO). Provincial accounts would be signed by the Provincial Medical Inspector and the WHO representative by bank transfer.

The GIBS and a few stakeholders at the MoH opposed allowing such large sums of funding to be managed in this way—especially when it came to keeping track of checks, invoices, and receipts—due to the lack of administrative structure for this at the DEP. This concern resulted in a push towards a proper PMU, which is now being established. One reason for the delay is that most stakeholders view this as an opportunity to create a PMU that could begin with GAVI HSS and eventually manage other large donor funds. The consultative process needed for all to approve the terms of reference, composition and functioning of such a PMU is a lengthy one. Although programmed for March 2009, the Global Fund technical assistance to be used to assess the needs of such a PMU has not yet begun.

c). HSS Implementation Experience/Capacity

It has been a challenge for the DEP to manage both planning and planned expenditures approved by the CNP. The DEP is very apt at producing strategies, studies and research but has limited field implementation experience, which has not previously been part of its mandate.

In March 2009, health zones were asked to prepare their development plans prior to the situational analysis, which was delayed and only began in July. There are stakeholders who favor the "bottom-up" approach of health zones developing their own situational analysis; there are others who would prefer a more "top-down" approach with the SPH as the lead in this assessment. Regardless, the delay in the situational analysis raises the question of how it will be used. As the NGOs and targeted provinces are currently conducting the HSS planning process, their capacity for implementation will be better determined over the next several months.

Many donors want to know if GAVI would be willing to extend the life of the HSS grant, as it is ending in 2011. The DEP has not raised the issue, but they are aware that they are behind in the implementation of the grant.

Capacity to allocate, manage, account for and spend GAVI HSS funding as planned

The delays in implementation due to how long it has taken to select a fiduciary agent has slowed this process. The large sums of money that need to be disbursed are also difficult to draw down from the bank and have associated high bank fees. Another key issue is that the DEP, as the executing agency, does not have a dedicated staff person to manage this process and work with the provinces and the health zones. The current DEP Director is multi-tasking on other technical priorities, including managing the Belgian Technical Cooperation component for planning and research. In July 2009, an offer was made to a project manager to assist with the HSS; it is expected that this person will start soon and manage the day-to-day activities of the project. Once the health zone Development Plans are agreed upon, the NGOs identified should be able to manage the HSS implementation funds if they are able to model their management after the positive experience and lessons learned from the CSO grant management.

Capacity to monitor HSS performance targets and use monitoring data to revise the HSS approach

This capacity needs to be further developed in-country, with a better defined process for how HSS performance will be monitored and which unit will be responsible for tracking HSS performance. As stated in previous sections, there are a number of indicators that do not correspond with the existing HMIS. As part of this study, the SPH developed a tracking tool to expand on the framework developed for the proposal, which includes indicators to help monitor HSS performance targets (see Annex 5).

Given the delay in implementation, revision of the HSS approach is not currently being considered. However, DRC may need to reconsider some of the target health zones, notably those that had a partner providing complementarity and additionality of HSS funding, as there are a number of zones which no longer meet that criteria.

Monitoring the incentive payments of health staff will be a challenge and is a priority for the CNP. An initial agreement was reached among the partners as to how to standardize the incentive payments. As noted previously, as part of this study, the SPH developed a draft operational research tool that was provided to the DEP for consideration. Operational research funding is included in the HSS grant, so this draft tool could be further developed and implemented to assist in defining how incentive payments will be monitored and tracked to determine impact.

Application of Paris Declaration and other GAVI HSS principles during implementation

Due to the delay in implementation, the study was unable to provide details on this. Based on current discussions and the involvement of CSOs, CNP members, and provincial and health zones teams, it is likely that these conditions will be met. However, because of various donor practices and past programs, the issue of harmonizing and monitoring salary supplements among donors and with the HSS remains to be resolved.

Progress toward expected outputs and outcomes

As of July 2009, the outputs and outcomes indicated in the proposal for the first two years—*including improved immunization coverage and child survival rates*—will not be met, as funding has not yet reached the health zones for implementation.

IX. Recommendations

a). To country decisions makers, stakeholders and donors

1. Ensure that the CNP and DEP provide more information to stakeholders through regular briefings or other mechanisms

The Country Case Study workshop showed that many stakeholders were not informed of the developments of the HSS activities and plans in DRC. Discussions with stakeholders (notably NGOs and other divisions at the MoH) can provide input on how to implement activities. This could be achieved through more frequent (possibly quarterly) meetings with stakeholders on HSS implementation. In addition, the calendar of activities should be revised to reflect the substantial implementation delay.

2. Apply the CSO grant experience and immunization provincial ICCC model

- The CSO grant is an example on how funding can flow to health zones. DRC has a long tradition of using NGOs to support and provide health services to health zones. Lessons can be learned from this experience, both in terms of financing models for health zones and implementation.
- The Inter-Agency Provincial Committees were created for the immunization program. These committees are not functional in all provinces and may need additional support from the HSS GAVI funds.

3. Create links between the new MoH/PMU and the fiduciary agent

- A Project Management Unit will soon be operational within the MoH. Roles and responsibilities between the PMU and the GAVI HSS fiduciary agent need to be established and transparent, as the two will function separately.

4. Put into place the audit systems as described in the proposal

- The GAVI HSS proposal includes a number of audits (internal and external) to be conducted during implementation and before the end of the grant. To date, these have not been put in place. As the burn rate increases, it is important for these audits to be in place to avoid possible implementation issues at a later stage.

5. Provide the necessary support to provinces as outlined in the proposal

- Support to the provinces has not yet begun. Provinces are to support the health zone DPs and budgets prepared by the health zones, but the current plans received by the DEP were not reviewed by the provinces.
- The roles of governors, provincial ministers of health, and provincial medical officers should be clarified as part of the CPP mandate.
- The CNP, in its role of inter-agency coordinator, needs to inform and provide assistance to intermediate levels in order to increase their understanding and participation in the HSS process.

6. Use the two tools developed by the School of Public Health

- The HSS indicator tool can be used with the existing HMIS to ensure complementary tracking of HSS implementation and impact. The operational research tool will be useful to measure the impact of the salary supplements provided through the GAVI HSS grant. Operations research is budgeted in the HSS grant, so the CNP and the DEP should use these funds to incorporate this study protocol and fund its implementation.

7. Harmonize the salary supplements strategy

- There are various salary supplement systems being implemented in DRC, based more on donors' experiences than a national consensus of what works and what has impact. As 25 percent of the GAVI HSS proposal goes to salary supplements, the CNP would benefit from having a defined vision of how it plans to provide and track these funds to the health zones.

8. Operationalize the human resources component of the GAVI HSS grant

- The links with institutions working on human resources issues (e.g., Department of Secondary Education, universities and other training entities) should be strengthened.

b). To the GAVI Alliance

- Prior to the disbursement of funds, verify that there is an existing financial management structure **in place** to ensure proper fund flow to recipients and proper financial management. The absence of such a structure is the main reason for the implementation delay in DRC.
- Request a timeline for the set-up/operationalization of the financial management structure.

The MoH added two recommendations:

- Should a country HSS financial management structure not already exist, consider a two-phase grant mechanism that enables the country to first set up a structure and then provide funds for implementation through a second phase.
- Document and disseminate DRC's experience with the CSO grant as a potential model for HSS implementation and financial management.

c). To other countries applying for or preparing implementation of GAVI HSS funds

- Ensure that there is a "blue print" document that will provide a basis for the HSS. As was the case with the GAVI process in DRC, have a national HSS strategy prior to initiating the proposal writing.

- Maintain a continuous flow of information to stakeholders and donors to update and involve them in HSS implementation issues.

X. Annexes

Annex 1: Liste Des Personnes Interviewees Dans Le Cadre De L'etude GAVI RSS (2009)

Liste des abréviations

AG : administrateur gestionnaire
AS : aire de santé
BCZS : bureau central de la zone de santé
CS : centre de santé
DN : directeur de nursing
DPS : division provinciale de la santé
ECZ : équipe cadre de la zone de santé
HGR : hôpital général de référence
IT : infirmier titulaire
MCS : médecin chef de staff
MCZ : médecin chef de zone de santé
MDH : médecin directeur de l'hôpital
MIP : médecin inspecteur provincial
ZS : zone de santé

LISTE DES PERSONNES AYANT PARTICIPE AUX FOCUS GROUP

GAVI SRSS DANS LA VILLE PROVINCE DE KINSHASA

I. INSPECTION PROVINCIALE DE LA SANTE

1. Madame MASASU FAUSTINE ; Administrateur Général à l'inspection provinciale.
2. Dr MONA, médecin chef d'antenne PEV Kinshasa Ouest. représentant le Médecin coordonnateur provincial du Programme Elargi de Vaccination

II.1 Entretien avec l'équipe cadre de la zone de santé (ECZ)

1. Dr Pélagie MOHINDA : Médecin chef de zone
2. Mme Elisée KALUBI : Administrateur gestionnaire
3. Benoît NGOYI : Animateur communautaire de la zone de santé
4. Alexis MISAMU : Infirmier superviseur de la zone de santé

II.2 Entretien avec les infirmiers commis à la vaccination

1. NDONGALA KIANZOLANI : IT au CS Shaloom dans l'AS MABULU II
2. MUDIPANU Jeannette : Infirmière au CS Saint Clément
3. KASONGO Théo : IT au CS la charité
4. KIAMBI Aniece : IT au CS Clémence dans l'AS KWANGO
5. Maman Monique : Infirmière dans la ZS MAKALA

III. ZONE DE SANTE KOKOLO

III.1 Entretien avec l'équipe cadre de la zone de santé (ECZ)

1. Dr Gustave MUNDU : Médecin chef de zone
2. José MILANDU : Infirmier superviseur
3. Mme Adarine MAPUMA : nutritionniste
4. Lieutenant François KALUILA : Technicien d'assainissement
5. Lieutenant ILUNGA : Mobilisateur de la zone de santé
6. KALUKU DIBONGA : Pharmacien
7. Capitaine marie Madeleine SONA : Administrateur gestionnaire

III.2 les infirmiers commis à la vaccination

1. Maman KULU : Infirmière chef de service de vaccination
2. Madame TUBASOMBA : Infirmière commise à la vaccination au CS KOKOLO
3. Mme VERO MAYINDO : Infirmière au CS KOKOLO
4. MILANDU : Infirmier superviseur de la ZS KOKOLO
5. Mme MWAMBA Edmond : Cliente au CPS

LISTE DES PERSONNES AYANT PARTICIPE AUX FOCUS GROUP

GAVI SRSS DANS PROVINCE DU SUD KIVU

La Division Provinciale de la Santé (DPS)

1. Dr MANU BURHOLE, Médecin Inspecteur Provincial (MIP)
2. Dr PIKO BOKUMU, Médecin Coordonnateur Provincial du PEV (MCP/PEV)
3. Dr ZOZO, Médecin Chef du 5ème bureau (SNIS)
4. Dr BAHIZIRE Apollinaire, Médecin responsable de Bureau d'étude et planification.

6.2.1. La zone de santé de Kalehe

6.2.1.1. L'Equipe Cadre de la zone de santé

1. Dr KULIMISHI, Médecin Chef de zone de santé
2. Mr SAIDI Claude, Administrateur Gestionnaire de la zone de santé
3. Mr LUAMBAZI Roger, Infirmer Superviseur chargé des activités PEV
4. Mr MITUGA Aimé, Nutritionniste de la zone de santé

6.2.1.2. Les infirmiers commis à la vaccination

1. AKSANTI BIRIGAMINE Seraphin, Infirmier à l'HGR ;
2. MULUME SANGARA Norbert, IT du CS Muhongoza ;
3. MUREGWA Oscar, IT du CS Kalehe ;
4. BASEME KARAMBA, IT du CS Mushemi.

6.2.2. **La zone de santé de Bagira – Kasha**

6.2.2.1. L'Equipe cadre de la zone de santé

1. Dr BASWIRA FURAHA, Médecin Chef de zone de santé de Bagira – Kasha ;
2. Mr YALALA Pascal, Administrateur Gestionnaire de la zone de santé de Bagira ;
3. Mr BASODA Pascal, Nutritionniste superviseur de la zone de santé de Bagira ;
4. Mr HABABWEMA MIDERO Platon, Infirmer Superviseur/PEV de la zone de santé de Bagira.

6.2.2.2. Les infirmiers commis à la vaccination

1. Mme MASTAKI CIREZI, Directrice de nursing à l'HGR de Bagira ;
2. Mr MAPINZI NGWASHI Christophe, IT du CS Diocésain Lumu, zone de santé de Bagira – Kasha ;
3. Mr HABABWEMA MIDERO Platon, IS de la zone de santé de Bagira - Kasha ;
4. Mr BWEMERE BAGUMA Clovis, IT du CS Nyamuhinga, zone de santé de Bagira – Kasha.

6.2.3. La zone de santé d'Uvira

6.2.3.1. L'Equipe cadre de la zone de santé

1. Dr KAPAMA Aloïs, Médecin Chef de zone de santé d'Uvira ;
2. Dr KANYONYO, Médecin Chef d'Antenne PEV, District sanitaire d'Uvira ;
3. Mr BAHIMBA Bernard, Infirmier Supérieur de la zone de santé d'Uvira ;
4. Mr BITAWA Bonde Gusi, Directeur de Nursing de l'HGR d'Uvira.

6.2.3.2. Les infirmiers commis à la vaccination

1. Mr MUKAMBA MABUNDA Alexis, IT CS Mulongwe, zone de santé d'Uvira ;
2. Mr MAZONGOLOKO Manie, IT du CS Kirungu Moyen Plateau, ZS d'Uvira ;
3. Mr ZABENE KABWANDA, IT du CS Kalundu CEPAC, zone de santé d'Uvira ;
4. Mr BAHIMBA Bernard, IS de la zone de santé d'Uvira ;
5. Mr NDUNGU CHIYIKA Olivier, IT du CSR Kalundu Catholique, zone de santé d'Uvira ;
6. Sr MULALI Laeticia, IT du CS Tanganyika, zone de santé d'Uvira ;

LISTE DES PERSONNES AYANT PARTICIPE AUX FOCUS GROUP

GAVI SRSS DANS PROVINCE DU BAS - CONGO

Dans la Province du Bas Congo, l'interview avait eu lieu seulement au niveau de la Division Provinciale de la Santé (DPS).

1. Dr TSASA Louis, Médecin Inspecteur Provincial (MIP), a.i
2. Dr MABUNDA Jean Baptiste, Médecin Coordonnateur Provincial du PEV (MCP/PEV)
3. Dr FONDANE Pierrot, Médecin Chef du 5ème bureau.

LISTE DES PERSONNES AYANT PARTICIPE AUX FOCUS GROUP

GAVI SRSS DANS PROVINCE DE L'EQUATEUR (DISTRICT DU SUD UBANGUI

I. Zone de Santé de TANDALA

Equipe Cadre de la Zone de Santé

1. Dr Narcisse Embeke (NAIA) : MCZ
2. Lembunzi Lole : ISME
3. Alphonse Alemba Kozo IS/ZS : (SSP)
4. Pelemgamo Saba : DN
5. Pepo Dikanda : A.G.

Infirmiers commis à la vaccination

1. Samuel IZE – ITINZAGO : I.T. CS BONGBIA TANDALA (Infirmier)
2. Gisèle DENAMBILI SAZA : I.T. CS BOZOMBALI (Infirmière)

II.

III. Zone de Santé de KUNGU

Equipe Cadre de la Zone de Santé

1. Dr Lucien EKWAKOLA : MCZ
2. BUNDA EBALE : DN / HGR
3. MOPENDA WA KUKU : Intendant

Infirmiers commis à la vaccination

1. LIKOLO LIKUMBELO : I.T. CSP (centre de santé pilote) de KUNGU (Infirmier)
2. NTUMBA BOLYIA : I.T.A. CS BODUBWA (Infirmier)

IV. Zone de Santé de BUDJALA

Equipe Cadre de la Zone de Santé

1. Dr MIAKASISA MBILU : MCZ
2. MATONDO PHELO : MDH
3. BATEGI BALANDI : IS
4. LONGELE MONYANNYO : AGZS
5. KPADO TOTEANAGO : DN

Infirmiers commis à la vaccination

1. Joël MANA LEKANDELO : I.T. CS EVECHE/BUDJALA (Infirmier)
2. Jonas MUKAMBA DENDELE : I.T. NZEKA TALIBA (Infirmier)

LISTE DES PERSONNES AYANT PARTICIPE AUX FOCUS GROUP

GAVI SRSS DANS PROVINCE DU KASAI ORIENTAL

I. Zone de Santé de KABEYA KAMUANGA

Equipe Cadre de la Zone de Santé

1. Dr MOISE KALONJI : MDH
2. FERDINAND TSHIANGATA : AG
3. PASCAL MUAMBA : DN
4. POLYCARPE NGANDU : SUPERVISEUR
5. MARTIN MPOYI : SUPERVISEUR
6. KAZADI : SUPERVISEUR
7. VICTOR MULUMBA : MOSO

Infirmiers commis à la vaccination

1. STANYSLAS KALONJI : IT CIACIACIA
2. BONAVENTURE MUFUTA : IT BADIBANGA
3. ADOLPHE MUAMBA MBAYA : IT DIKUDI
4. JUSTIN TSHIBANGU : IT KALOMED
5. CHRISTOPHE MWANZA : IT CINCIANKU
6. EMERY NDUMBULULA : IT KABEYA MILEMBE
7. JEAN LUMBALA : IT DIBULA
8. MOISE NGANDU : l'infirmier du PS LAC FWA
9. VICTOR MULOWAYI : IT TSHIONDO
10. MOISE MUKENDI : IT LAC MUNKAMBA
11. JUSTIN MICHEL MBIYA NGANDU : IT MPANDA
12. REMY KABANTU MPETU : IT MATADI

II. Zone de Santé de LUSAMBO

Equipe Cadre de la Zone de Santé

1. Dr VICKY MULUMBA : MDH
2. AG TOTAMBA : AG
3. DENIS KAMBALA : Secrétaire
4. HENRIETTE SHAKO : Préposée à la Pharmacie
5. GEORGES MUSUNGIDIBUE : DN
6. ANDRE : SUPERVISUER
7. ROSE TSHIALA : SUPERVISEUR

Infirmiers commis à la vaccination

1. TSHIYEKELA KASONGO : IT LUKENGU
2. DJONGA PONGO SHAMBUYI : IT LUS OUEST
3. NSEMBUE ILUNGA : IT MUKUASA
4. TSHATSHI AHANO : IT CS LUNKALA
5. MUAKA MISHIDI : IT LUS EST
6. TSHILUBUISHA KUMUAMBA BASILE : IT MFUILA T TSHINYI

III. Zone de Santé de TSHISHIMBI

Equipe Cadre de la Zone de Santé

1. Dr JULIENNE TSHIOWA : MCZ
2. Dr PIERROT KAYEMBE : MDH
3. JEAN MUTEBA : SUPERVISEUR
4. SAMY NYEMBO : SUPERVISEUR

5. PASCAL KAZEMBA : SUPERVISEUR
6. LEOPOLD NSENGA : SUPERVISEUR
7. ALAIN MAKOLAT : SECRETAIRE
8. JOSEPH KABENGELE : LOGISTICIEN

Infirmiers commis à la vaccination

1. DANIEL KALENGA : IT BON BERGER
2. ALIS CIMANGA : IT C.N.M
3. JAS MBUYI ILUNGA : IT NZEVU TSHILANDA
4. ANDRE BITANGILAYI : IT BAKUA TSHIMUNA
5. PASCAL KALAMBA : IT MPUMBUA
6. PAPY MBUYAMBA NKASHAMA : IT BAKUA HOYI
7. BERNARD TSHIPATA KALENGAY : IT MUDIBA
8. RICHARD KAZADI : IT TSHIANGA
9. PAPY TOSUWA : IT MUKEBA
10. SERGE MULUMBA : IT BENA MBALA

Focus Groups avec les personnels de 1er, 2ème et 5ème Bureau de la Province du KASAI ORIENTAL

1. JUSTIN KIBU : Chargé de partenariat au 5ème bureau
2. THERESE KASONGO : Secrétaire chargée de SNIS au 5ème bureau
3. SEBASTIEN KAZADI : AG/ B1/ chargé des ressources humaines
4. HENRI KABALA MULENDA : Secrétaire 2ème bureau
5. ANDRE MBUYAMBA KALUBI : 2ème bureau
6. FREDDY MAMPANYA : Opérateur phoniste DPS
7. MBOMBO DIKEMU : Secrétaire 1er bureau

Focus Groups avec les membre des CPP de la Province du KASAI ORIENTAL

1. Dr MUAMBA DIANGO : MIP
2. Dr KAZADI : Président de la Commission chargée de prestation, de mise en œuvre, de suivi et évaluation
3. Dr KANKONDE : Président de la Commission chargée de lutte contre la maladie et la gestion de catastrophe
4. Dr TUTU MUKUNA : Président de la commission chargée de politique, planification et programmation
5. A KASHOMONA : Président de la Commission chargée de financement, contractualisation et budgétisation
6. AG LUFULUABU : Membre

LISTE DES PERSONNES : PROVINCE DU KATANGA

INSPECTION PROVINCIALE

- Dr Mukomena Eric
- Dr Kapalale
- Dr Mamie Ilunga
- Dr Moma Franck
- Mr Assumani : Chef du personnel
- Mr Kumba : AG
- Dr Nathalie Mulongo

- Dr Lukanka Olivier
- Mr Tshisekedi : AG

EQUIPE CADRE DE KABALO

- Dr PATRICE KUMWIMBA WA ILUNGA : MCZ KABALO
- JEAN KONGOLO MANGALA, IT en Soins de Santé Primaire

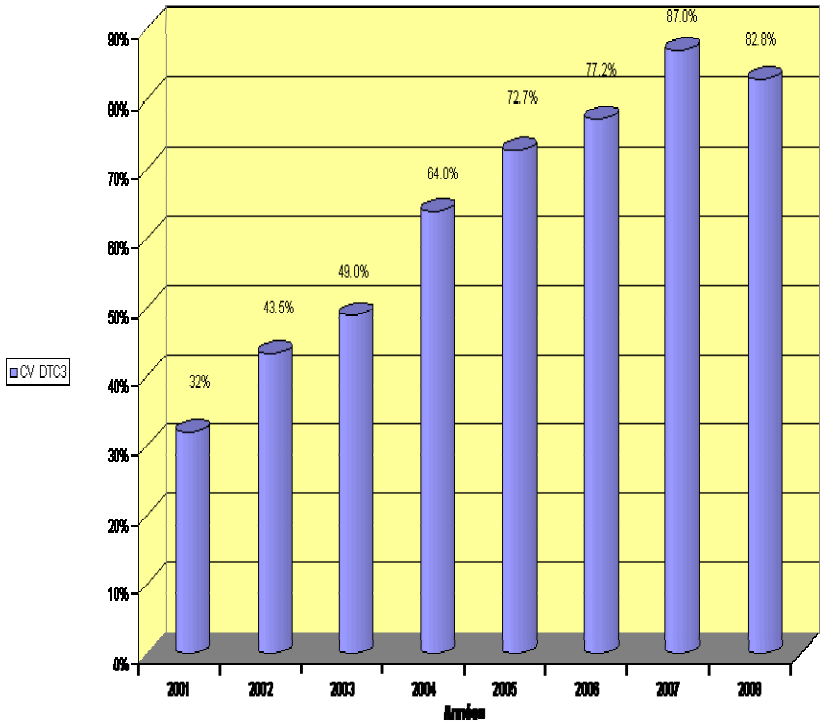
Zone de Moba

- Dr Rigobert
- MR Jean Jacques Ilunga
- Mr Kasongo Kabeke

Zone de Santé de Kalemie

- Dr Ngandwe Adalbert
- Mr Emmanuel Muana Ngoyi
- Mr Amisi
- Mr Mubanga Ngoyi Muimbi
- Mr Breton

Annex 2: Immunization Coverage Rate, DRC[25]



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[25] Provided to the EPI program to the JSI Team, December 2008

Annex 3: Comparison of WHO/UNICEF JRF Data And Mics/DHS Data

Coverage estimates

DHS in 2007/MICS2 in 2001								
	2007	2006	2005	2004	2003	2002	2001	2000
BCG		72					53	
DTP1		71					51	
DTP3		**45**					**30**	
Measles		63					46	
WHO-UNICEF coverage estimates								
	2007	2006	2005	2004	2003	2002	2001	2000
BCG	94	87	84	78	68	57	65	57
DTP1	95	87	82	76	61	49	60	-
DTP3	**87**	**77**	**73**	**64**	**49**	**40**	**35**	**-**
Measles	79	73	70	64	54	46	38	18
Official country estimates (administrative data)								
	2007	2006	2005	2004	2003	2002	2001	2000
BCG	94	87	84	78	68	57	-	-
DTP1	95	87	82	76	61	49	-	-
DTP3	**87**	**77**	**73**	**64**	**49**	**40**	**-**	**-**
Measles	79	73	70	64	54	46	-	-

Annex 4: DPT3 Coverage from multiple sources (Government-reported coverage, UNICEF-WHO Joint Reporting Forms, and Data Modeled from Household Survey Data.

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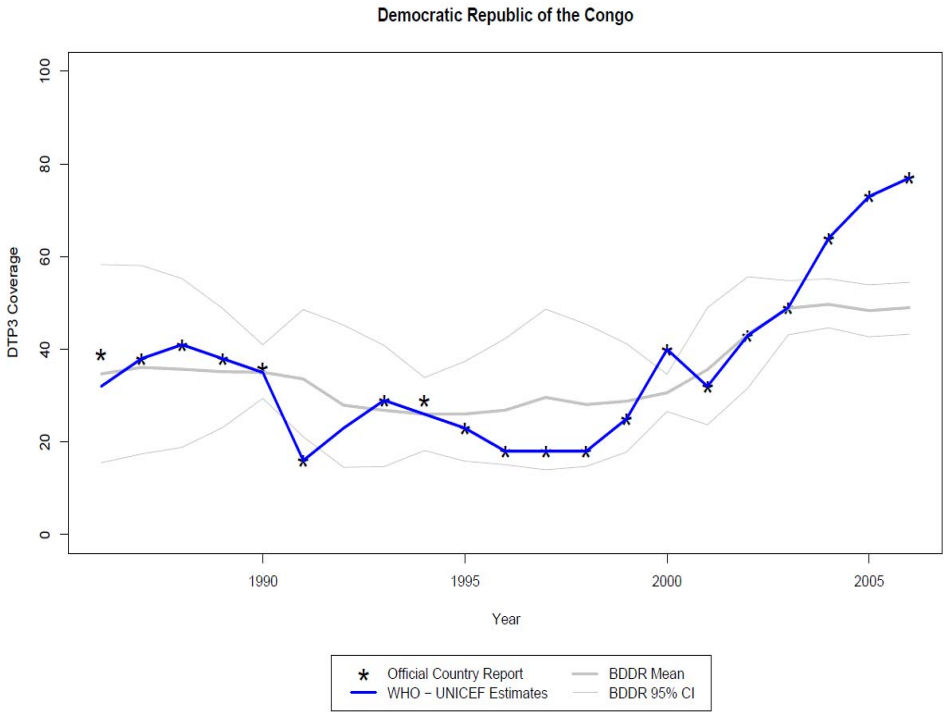

Source: http://www.healthmetricsandevaluation.org/resources/datasets/dtp3/dtp3_data.php

Annex 5: GAVI RSS indicateurs

.....	N°	BUDGET ($)	RESPONSABLE	ETAPES	INDICATEURS	DEFINITION DE L'INDICATEUR	SOURCES de VERIFICATION	DATE
COMITE NATIONAL DE PILOTAGE DE LA SRSS								
Suivi de la mise en œuvre des PPDS	**I.10**	576,000	CNP	Elaboration du canevass de suivi + indicateurs du suivi de la mise en oeuvre	1) % des provinces ayant reçu la liste des indicateurs de suivi de la mise en œuvre élaboré par le CNP	1) Nombre des provinces ayant un document donnant les directives, procédures et les indicateurs élaboré par le niveau central	Rapport d'évaluation: Rapport annuel SNIS: Copie du document de canevas	2009-2012
					2) % des provinces ayant reçu des missions de suivi du niveau central	2) Nombre des provinces ayant reçu des missions de suivi du niveau central sur l'ensemble des provinces appuyées par GAVI	Rapport de mission: SOUMIS au S.G.	
COMITES PROVINCIAUX DE PILOTAGE								
				1) Elaboration d'un plan d'appui au fonctionnement des 3 CPP	1) % des provinces disposant d'un plan d'appui validé par le CPP	1) Nombre des provinces disposant d'un document écrit donnant les détails sur tous les appuis qui seront fournis aux CPP ciblés sur l'ensemble des provinces ciblées	Rapports annuels GAVI	
Appui au fonctionnement des 3 CPP de la SRSS	**II.1**	794,800	CNP	2) Validation du plan d'appui par le CNP	2) % des provinces ayant reçu un appui au fonctionnement	2) Nombre des provinces dont les CPP ont reçu un appui au fonctionnement sur le nombre des provinces prévues dans le cadre de l'appui de GAVI	Rapports des revues annuelles provinciales et nationnales	2009-2012
				3) Exécution du plan d'appui au fonctionnement des 3 CPP			Rapports GAVI:	
				1) Elaboration des TDRs	1) % des provinces ayant élaboré des TDRs d'un atelier de planification provinciale et/ou revue provinciale	1) Nombre des provinces disposant d'un document écrit précisant les termes de référence de l'organisation d'un atelier de planification au niveau provincial et/ou revues provinciales sur l'ensemble des provinces ciblées	Copie du document des TDRs	

Organiser un atelier de planification au niveau provincial et/ou revues provinciales	**II.3**	480,000	DPS	2) Elaboration du calendrier de l'atelier de planification au nieau provincial et/ou revue provinciale	2) % des provinces qui disposent d'un plan provincial	2) Nombre des provinces disposant d'un plan provincial.	Copie du plan validé	2009-2012
				3) Convocation de l'atelier de planification et/ou revue provinciale				
				1) Elaboration du canevass de supervision	1) % des provinces ayant élaboré un canevass de supervision des ZS	1) Nombre des provinces disposant d'un document écrit précisant les détails sur les directives (instructions) du déroulement de la mission de supervision effectuées par l'ECP dans les ZS ciblées sur l'ensemble des provinces ciblées	Copie du document de canevas de supervision	
Supervision des ZS par la province	**II.4**	160,000	DPS	2) Elaboration d'un calendrier de supervision	2) % des provinces ayant établi un calendrier de supervision des ZS	2) Nombre des provinces disposant d'un document écrit précisant les dates où seront tenues les missions de supervision de l'ECP dans les ZS ciblées sur l'ensemble des provinces ciblées	Copie du document de calendrier de supervision	2009-2012
				3) Conduite de la supervision	3) % des ZS ayant reçu une mission de supervision des ZS réalisée par l'ECP	3) Nombre des ZS ayant reçu une mission de supervision de l'ECP sur l'ensemble des ZS ciblées sur l'ensemble des provinces ciblées	Rapport de supervision préparé par l'ECP	
				1) Elaboration du canevass de supervision	1) % des districts sanitaires ayant élaboré un canevass de supervision des ZS	1) Nombre des districts disposant d'un document écrit précisant les détails sur les directives (instructions) du déroulement de la mission de supervision effectuées par l'Equipe Cadre du district sanitaire dans les ZS ciblées	Copie du document de canevas de supervision	

Supervision des ZS par le district sanitaire	**II.5**	320,000	DS	2) Elaboration d'un calendrier de supervision	2) % des districts sanitaires ayant établit un calendrier de supervision des ZS	2) Nombre des districts disposant d'un document écrit précisant les dates où seront tenues les missions de supervision de l'Equipe Cadre du district sanitaire dans les ZS ciblées sur l'ensemble des districts ciblés	Copie du document de calendrier de supervision	2009-2012
				3) Conduite de la supervision	3) % des ZS ayant reçu une mission de supervision des ZS réalisée par l'Equipe Cadre du district sanitaire	3) Nombre des ZS ayant reçu une mission de supervision de l'Equipe Cadre du district sanitaire sur l'ensemble des ZS ciblées sur l'ensemble des districts ciblés	Rapport de supervision préparé par l'Equipe Cadre du District Sanitaire	
DEVELOPPEMENT DES ZONES DE SANTE								
				1) Elaboration du plan	1) % des ZS ayant élaboré des PDSZ	1) Nombre des ZS ayant élaboré les PDSZ sur l'ensemble des ZS ciblées	Rapports annuels de la zone de santé	
Elaboration des PDSZ	**III.2**	520,000	ECZ	2) Validation du plan	2) % des ZS dont les PDSZ ont été approuvé et validé par le conseil d'administration de la zone de santé	2) Nombre des ZS qui disposent des PDSZ approuvé et validé par le CPP dans l'ensemble des ZS appuyées par GAVI	Rapports des revues annuelles provinciales.	2009-2012
				3) Exécution du Plan	3) % des ZS ayant démaré la mise en œuvre du plan	3) Nombre de ZS dont les PDSZ ont commencé à être mis en œuvre sur l'ensemble des ZS ciblées	Rapport d'activités de la ZS	
				1) Identification d'un état de besoins	% des HGR réhabilités	Nombre des HGR réhabilités par rapport au nombre des HGR planifiés pour la réhabilitation	Rapport d'activité de la ZS	
Réhabilitation/construction des CS et des HGR	**III.3**	5,370,000	ECZ, DPS et DS	2) Appel d'offre		Nombre des HGR construits par rapport au nombre des HGR planifiés pour la construction	P.V. de reception des travaux	2009-2011
				3) Passation de marché	% des CS réhabilités	Nombre des CSR réhabilités par rapport au nombre des CSR planifiés pour la réhabilitation		
				4) Réhabilitation / Exécution des travaux	% des CS construits	Nombre des CSR construits par rapport au nombre des CSR planifiés pour la construction		
			BCZS et DPS	1) Identification d'un état des besoins (Etat des lieux)	% des HGR équipés	Nombre des HGR équipés par rapport au nombre des HGR planifiés pour être équipés	Rapport d'activité des HGR et CSR	
Equipement des CS et HGR	**III.4**	7,744,500		2) Appel d'offre			Lettre d'envoie des équipements	2009-2012

				3) Passation de marché	% des CS équipés	Nombre des CSR équipés par rapport au nombre des CSR planifiés pour être équipés	P.V. de reception des équipements	
				4) livraison			Fiches d'inventaires	
				1) Elaboration du canevass de supervision	1) % des ZS ayant élaboré un canevass de supervision des CS	1) Nombre des BCZ disposant d'un document écrit précisant les détails sur les directives (instructions) du déroulement de la mission de supervision effectuées par l'ECZ dans les CS ciblées sur l'ensemble des ZS ciblées	Copie du document de canevas de supervision	
Supervision des activités des CS	**III.6**	468,000	ECZ	2) Elaboration d'un calendrier de supervision	2) l'existence du plan de renforcement de capacité	2) Nombre BCZ disposant d'un document écrit précisant les dates où seront tenues les missions de supervision de l'ECZ dans les CS ciblées sur l'ensemble des ZS ciblées	Copie du document de calendrier de supervision	2009-2012
				3) Conduite de la supervision	3) % des CS ayant reçu une mission de supervision réalisée par l'ECZ	3) Nombre des ZS ayant reçu une mission de supervision de l'ECZ dans les CS sur l'ensemble des ZS ciblées	Rapport de supervision préparé par l'ECZ	
DEVELOPPEMENT DES RESSOURCES HUMAINES								
				1) Identification des besoins de renforcement des capacités	1) % des provinces ayant un plan de renforcement des capacités des ressources humaines	1) Nombre des provinces disposant d'un plan de renforcement des capacités de ressources humaines sur l'ensemble des provinces appuyées par GAVI	1) Copie du plan de renforcement capacités	
Renforcer les capacités des équipes cadres provinciales	**IV.2**	252,000	DEP/5ème Direction	2) Elaboration d'un plan de renforcement des capacutés	2) L'existence du plan de renforcement de capacité.	2) Nombre des provinces disposant d'un document écrit précisant les termes de référence du plan de renforcement des capacités des équipes cadres provinciales sur l'ensemble des province ciblées		2009-2012
				3) Validation du plan de renforcement des capacités	3) L'existence des modules de renforcement des capacités	3) Nombre des provinces disposant d'un module de renforcement des capacités sur l'ensemble des provinces appuyées par GAVI	3) Copie du module pour le renforcement des capacités	
				4) Organisation de la formation / recyclage	4) % des provinces dont les cadres des Equipe Cadre des Provinces ont bénéficié d'une formation en matière de renforcement des capacités	4) Nombre des provinces dont les cadres de leurs Equipes Cadre Provinciales ont bénéficié d'une formation sur l'ensemble des provinces appuyées par GAVI	4) Rapport d'activités de l'ECP 5) Rapport des ateliers de formation élaborés par les formateurs	