Health System Strengthening (HSS) Cash Support Application Package – Proposal Form

Application Package – Proposal Form

COUNTRY NAME: __CONGO_____ **APPLICATION DATE: 25 January 2015**

This proposal form is for use by applicants seeking to request Health System Strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organizations (CSOs), in the development of HSS proposals prior to submission of this application for funding.

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PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1- **Summary of a Complete Application**

Countries may wish to attach additional national documents as necessary. → Please place an 'X' in the box when the attachment is included		
No.	*Document*	X
1.	HSS Proposal Form	X
2.	Signature Sheet for Ministry of Health, Ministry of Finance and HSCC members	X
3.	Minutes of ICC Meeting Endorsing Proposal	X
4.	HSS Monitoring & Evaluation Framework	X
5.	Detailed workplan and budget	X
6.	Detailed Procurement Plan (18-month)	X

Existing National Documents - Mandatory Attachments Where possible, please attach approved national documents rather than drafts. For a decentralized country, provide relevant state/provincial level plan as well as any relevant national level documents.		
No.	*Document*	X
7.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS services	X
8.	National M&E Plan (for the health sector/strategy)	X
9.	National cMYP	X
10.	Vaccine assessments (EVM, post-introduction assessment, EPI reviews), if available	X
11.	Health Sector Coordinating Committee Mandate (ICC)	X
12.	Project assessment document for an application for credit in the amount of SDR 6.6 million (equal to US$ 10 million) and in the amount of US$ 10 million USD for the HRITF in Republic of Congo for a health system development project (HSDP II) (P143849)	X
13.	Order no. 2013-280 dated 25 June 2013 on the creation of Community Health Management Committees (CHMC)	X
14.	GAVI Plan for the Transfer of Responsibility	X
15.	EDS I	X
16.	EDSC II	X
17.	Order no. 3643/MSP/CAB/02 dated 09 October 2002 on the creation of the ICC	X
18.	ICC meeting minutes for 05/06/2014, 09/11/2014,05/13/2014 and 01/23/2015	
19.	MPH/WHO partnership agreement for joint WHO/UNICEF/UNFPA project	

20.	Order no. 2013-813 dated 30/12/2013 on organization of MPH	
21.	Final health system strengthening project evaluation report project for Congo (PASCOB)	
22.	National roadmap to accelerate the reduction of maternal, neonatal and child mortality	
23.	Expression of interest for new or extended GAVI support	
24.	Service note no. 000393 dated 08/08/2014 on nomination of technical work group members responsible for creating the application to GAVI-HSS, September 2014 session	
25.	Attendance list of the ICC Friday, January 23, 2015 meeting	
26.	2015-2016 Biennial Health Services Development Plan	
27.	National health accounts (2009-2010)	
28.	External EPI review for Congo conducted October-November 2014, interim report	
29.	Report of second Congolese household survey	
30.	Audit of Global Fund Grants to the Republic of the Congo	

1. Applicant Information	
Applicant:	Ministry of Health and Population
Country:	Republic of Congo
Proposal title:	Project to Strengthen the Health System in Congo Brazzaville
Proposed start date:	September 2015
Duration of support requested:	3 Years (01 September 2015 - 31 December 2017)
Total funding requested from GAVI:	4,420,000 USD
Contact Details	
Name	Mr. Jean Philippe Ngakosso
Organization and title	Director of Cabinet, Ministry of Health and Population
Telephone	00(242) 04 407 87 87 / 06 687 41 42 / 05 598 15 15
E-mail addresses	jeanphilippengakosso@yahoo.fr

1. Informations sur le candidat	
Candidat :	Ministère de la santé et de la Population
Pays :	République du Congo
Titre de la proposition :	Projet d'appui au renforcement du système de santé au Congo
Date de début proposée :	Janvier 2015
Durée du soutien demandé :	3 ANS
Financement total demandé à GAVI :	5,200,000 USD
Coordonnées de contact	
Nom	Mr. Jean Philippe NGAKOSSO
Organisation et titre	Directeur de Cabinet, Ministère de la santé et de la Population
Téléphone	00(242) 04 407 87 87 / 06 687 41 42 / 05 598 15 15
Adresse électronique	jeanphilippengakosso@yahoo.fr

Signatures : aval du Gouvernement			
Ministères	**Noms du Ministre**	**Signatures**	**Dates**
Ministre de la Santé et de la Population	**Francois IBOVI**		21.1.2015
Ministre d'Etat, Ministre de l'économie des finances du plan du portefeuille public et de l'intégration	**Gilbert ONDONGO**		16 FEV 2015

Title / Organization	First and last names	Signature of those participating in the ICC meeting who have approved the proposal	Time lines
Director Minister's Cabinet	Jean Philippe Ngakosso		
Ministry of Finance Representative			
Representative of the Ministry of Planning			
Director of the Population	Yolande Voumbo Matoumona		
Director General of Epidemiology and Disease Prevention	Obengui		
Director General of Hospitals and Healthcare Organizations	Alexis Elira Dokekias		
DEP / MPH Director	Marcellin Lebela		
EPI Head	Hermann Boris Didi Ngossaki		
WHO Representative	Fatoumata Binta T. Diallo		
UNICEF Representative	Aloys Kamuragiye		
UNFPA Representative			
World Bank Representative			
AFD Representative			
CSO			
CSO			
CSO			
CSO			

Please check the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes **x** ☐ No ☐

Individual members of the HSCC may wish to send informal comments to: gavihss@gavialliance.org. All comments will be treated confidentially.

2. Detailed Budget and Workplan (2 pages maximum)

The HSS-GAVI proposal development process began in May 2013 after GAVI's visit to Congo.

During this visit, the authorities at the Ministry of Health and Population received official information that Congo was eligible for GAVI funding of US$ 5.2 million within the context of the plan that was put in place to support the country's health system strengthening (HSS-GAVI). To access these funds, Congo was required to notify the GAVI Secretariat of its Expression of Interest and then submit a proposal in accordance with GAVI guidelines.

Following notification of this information, Congo notified GAVI on 30 June 2014 of its Expression of Interest in submitting an application for health system strengthening. Drafting the Expression of Interest provided the Ministry of Health with the opportunity to assess the main bottlenecks that justify the low rate of immunization coverage and which are, for the most part, attributable to the fragile nature of the health districts as well as the inadequacies observed in district operations.

The Expression of Interest was followed by a series of contacts among key partners. The discussions dealt with: (i) the "Graduating Country" status: the HSS-GAVI funding is a major opportunity being offered to Congo to be better prepared for when it can no longer receive GAVI funds; (ii) funds management by WHO and UNICEF to facilitate the transparent and efficient implementation of interventions; (iii) the need to focus the project's interventions on reducing inequities, improving immunization coverage, and improving the country's M&E system; (iv) the crucial complementarity of GAVI-HSS with the Health Services Development Program (HSDP-II) and the WHO/UNICEF/UNFPA joint project to revitalize the health districts and (v) the requirement to conform to GAVI guidelines[1].

Per Memorandum no. 000393 dated 08 August 2014, the Ministry of Health and Population created a technical work group responsible for drafting the proposal, under Director of Cabinet's authority. Technical coordination will be ensured by the Research and Planning Department (DEP in French). This commission will include senior personnel from the General Office in charge of health care and services, the DEP, district hospitals, doctors with proven experience in management within the health districts, and senior personnel from the Expanded Program on Immunization (EPI). The work group benefited from technical and logistical support provided by the in-country offices of WHO and UNICEF.

During September and October 2014, the work group conducted field visits and interviews with health committee associations in Brazzaville's two health districts (Makélékélé and Talangaï), one of which has poor immunization performance. These interviews provided information on the committees' opinions as well as their lessons learned as related to the use of health services. They underlined the importance of community health worker participation at the community level when organizing the offering of essential care. The occasion of these visits was used to invite health committee association leaders to participate in meetings to discuss and approve features of the HSS-GAVI project.

In addition, the work group collected available documentation and organized technical discussions with the central directorates and technical departments specifically involved in organizing the offering of the essential packages of interventions. Mainly, this would be the departments in charge of IMCI, mother and child health, specific programs (malaria, tuberculosis, HIV/AIDS), the health information system, pharmacies and medication and human resources as well as health care and services. A similar approach was taken by the Brazzaville health district teams.
The document produced by the commission was the subject of a wider review organized on 16 to 17 January 2015, with participants including senior personnel from the different levels of the health system, the Ministry of Planning and Finance, delegates from Civil Society Organizations and communities as well as MPH partners who are directly involved such as WHO, UNICEF and the World Bank. Civil Society Organizations (CSOs) were particularly involved in the discussion, especially with regard to community

[1] Prevent GAVI funds from being used for the following: paying staff salaries and bonuses (the World Bank's PBF is to be used for that), purchasing vehicles (except for motorbikes and bicycles), procuring vaccines, paying for health staff to attend meetings out of the country. On the other hand, these funds are to be used to support planning, to strengthen the immunization system including the cold chain, and for the implementation of high-impact services

participation

During the entire draft submission process, the team used the studies conducted by the World Bank to their benefit, to finalize the Health Services Development Program 2014-2018 (HSDP-II)[2]. It is in this way that the application drafting process benefited from the input of CSOs, departments and health districts via contributions that they had submitted when the HSDP-II was being drafted.

The NGO *Médecins d'Afrique* - MDA [Doctors of Africa], CSO leaders involved, actively contributed to drafting this proposal.

During the process, the Inter-agency coordinating committee (ICC) validated the proposal during the meeting held on 22 January 2015. Members of the government signed the application after it was validated by the ICC.

It should be noted that application process was undertaken only shortly after the 2015-2016 PBDS was finalized; the PBDS is endorsed in the 2012-2016 NHDP, national strategic planning framework. For the most part, the overall health sector analyses were mainly taken from observations and results from the drafting of the 2015-2016 PBDS which was initially supposed to be an NHDP for the 2012-2016 period. The slow nature of the health sector strategic planning process that was observed led the Ministry of Health and Population to limit itself to this biennial program so as to remain in sync with the national strategic planning cycle.

[2] *Health Services Development Program (HSDP-II), pages 14-18*

3. Executive Summary

The trend toward fewer children who are fully immunized (52% according to EDSC-I and 46% according to EDSC-II) is worrisome and pushes out the time it will take for Congo to obtain MDGs 4 and 5. Even though the results of the 2014 external EPI review show an improvement with 75% of children being fully immunized, Congo's immunization system still has significant weaknesses.

These weak performances are the result of its fragile nature and the inadequacies observed in health district operations, of which the main bottlenecks [3]are the following: (i) the obsolescence of certain facilities, (ii) the lack of true health district management teams, trained with the tools for organizing, managing and providing the packages of activities; (iii) the poor quality and low numbers of staff in health facilities; (iv) lack of technical equipment, hardware and supplies in reference hospitals and health centers; (v) recurring shortages of medicines, vaccines and other inputs at health centers and health district hospitals; (vi) inadequate funding for the immunization program and activities implemented in the health districts; (vii) the absence of an operational NHIS; (viii) various logistical issues, especially those that interfere with the supervision of health center workers, such as the lack of vehicles and motorbikes; (ix) the weak level of planning and implementation for community outreach strategies, as well as a weak public-private partnership.[4]

All this explains the fact that, today, less than half of the health centers provide the complete packages of activities. In addition, this data reveal the continued inequities and disparities in what immunization services are offered and used, considering different socio-economic characteristics[5].

This proposal is targeting improved performance of the immunization infrastructure through health system strengthening via a vision of equity. The proposal simultaneously targets an increase in demand, the offer and use of health services, including immunization services. This project's interventions address the health districts with low immunization performance in priority. These health districts are, for the most part, located in zones that are difficult to access and which are home to vulnerable populations. These districts are located within the country's most populous areas; improved immunization coverage in these areas will have a major impact on national immunization coverage.

This project will have synergy with other programs and projects in the country that focused on strengthening the health system. There is particular synergy with the Health Services Development Program (HSDP-II) that is cofunded by the Congolese government and the World Bank for the amount of US$ 120 million. The joint health system strengthening project[6], which the Congolese government is expected to fund and which will be carried out by the three UN agencies (WHO, UNFPA and UNICEF), will offer an additional opportunity for synergy. In addition, there is also the Project to Support and Strengthen Paramedical Personnel (PARAMED in French) with the support of the French Development Agency. Within this same context, the plan to make Congo a GAVI graduating country was adopted and is expected to be implemented within the next few weeks.

The objectives targeted by this project are described below:

Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.

Whether or not this objective is reached will depend on the removal of constraints linked to the condition of facilities, human resources, medicines, supplies and technical equipment. The goal is for the IHCs within the targeted health districts to offer comprehensive and high-quality essential packages of interventions. To achieve this, the project includes light renovations at facilities, the availability of various inputs, training and retraining of staff on the essential package of service offerings, restoration of health facility functioning and structural operations and the integration of all required essential packages of services at these facilities, as well as monitoring and supervision of workers.

[3] *2015-2016 Biennial Health Services Development Plan, pages 25-50.*
[4] *2015-2016 Biennial Health Services Development Plan, page 50*
[5] *EDSC-II, 2011-2012, pages 12-15*
[6] *MPH/WHO-UNICEF-UNFPA joint project agreement*

Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.

Whether or not this objective is reached will depend on the continuity of the preceding objective. Reaching this objective will only be effective if bottlenecks like the lack of supervisory vehicles and weak community approaches are removed.
In addition to the initiatives in the preceding objective, there will be also be emphasis on strengthening the capacity of each health district to ensure immunization throughout the entire country. The focus will be on: (i) the acquisition and availability of vehicles required for the supervision and organization of mobile and outreach strategies; (ii) bringing the cold chain at the various levels up to standard; (iii) the training of IHC and health outpost works and members of the senior teams and EPI management team for immunizations and program management; (iv) support for the organization of outreach and mobile strategies in health areas, as well as (v) the supervision of workers and monitoring of immunization coverage per health zone.

Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.

Reaching this objective is closely linked to the reduction of constraints that affect the national health information system's functionality, which still remains very limited. This is why the HSS-GAVI support recommends providing the HDDs and health districts with computer equipment and modems for submitting NHIS data, providing support for electronic data entry and data processing for the NHIS in the health districts, training those who use the NHIS on data collection methods and techniques as well as data processing and analysis and regularly organized DQS and DQA.

Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.

In order to remove the constraints linked to the poor use of essential packages of interventions, including immunization, the use of mobile telephones is an appropriate response to the failure of the routine scheduling system in urban areas. Mobile phone technology will be used to generate an electronic schedule and reminder messages on the mobile phones of the parents of children who are scheduled for immunization.

Objective no. 5: From now until the project is complete, strengthen governance and program management.

Within this context, this involves: (i) advocacy to reorganize the EPI management structure, provide additional technical personnel and allow them to function with the authority of a central directorate, improve and secure funding for additional personnel; (ii) organize continuing education training sessions /retraining sessions for those involved in EPI planning, program monitoring and evaluation, management of the immunization process, cold chain equipment and data, and (iii) provide EPI management personnel with appropriate management tools.

Directly related to the project's objectives, the following key results will be observed at project implementation:

1. Quality essential packages of interventions including immunization be offered in at least 80% of the target health districts.
2. The percentage of children who are fully immunized in all health districts including groups within marginalized populations is increased to at least 85%.
3. At least 80% of the departmental directorates and health districts are producing quality data and periodic report that adhere to the formats and timelines recommended by the NHIS.
4. Increase the demand for essential packages of intervention offerings, including immunization, in the

targeted health districts, using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.

5. Governance and program management are to be strengthened

As shown through the project's objectives, this application is mainly focused on strengthening the health system to make immunization coverage sustainable. In addition, this project will focus on health districts that meet the following criteria: (i) low immunization coverage - less than 80% - in Pentavalent 3 and MCV, (ii) low or average immunization service usage rate, and (iii) recent epidemic.

In applying these criteria, 7 health districts were selected from 5 of the country's 12 departments. These health districts represent a total population of 1,517,289 which is more than one-third of the entire population of Congo. This information is shown in table 6, page 28.

TWO PAGES MAXIMUM

4. Acronyms	
Acronym	**Acronym Meaning**
RED	Reach Every District
AFD	Agence Française de Développement (French Development Agency)
AS	Health zone
IVA	Intensified Vaccination Activities
ICC	Inter-Agency Co-ordination Committee
MTEF	Medium-Term Expenditure Framework
CHMC	Community Health Management Committees
UHC	University Hospital Center
CNS	National Health Accounts
COSA	Comité de Santé (Health Committee)
PNC	Prenatal consultation
IHC	Integrated Health Center
VC	Vaccine Coverage
DHD	Health Department Directorates
DEP	Directorate for Planning and Research
DLM	Department of Disease Control
DQA	Data Quality Assessment
DQS	Data Quality Survey
HD	Circonscription Socio Sanitaire (Health District)
HD	Health District
HDD	Department of Health and Services
DTP	Diphtheria-Tetanus-Pertussis
ECOM	Congolese Household Survey
FIC	Immunization Coverage Survey
DHS	Demographic and Health Survey
EDSC	Demographic and Health Survey in Congo
RBF	Results-Based Financing
FMA	Financial Management Assessment
GAVI	Global Alliance for Vaccines and Immunization
EVM	Effective Vaccine Management
GFATM	Global Fund Against Aids Tuberculosis and Malaria
BH	Basic Hospital
Hep B	Hepatitis B Vaccine
HERA	Health Research for Action
Hib	Haemophilus influenzae type b vaccine
SFI	Total Fertility Rate
JRF	Joint Rapport Form
AEFI	Adverse Events Following Immunization
MICS	Multiple Indicator Cluster Survey
MLM	Middle Level Management
NITAG	National Immunization Technical Advisory Group
NTIC	New Technologies and Information
OMD	Millennium Development Goals
WHO	World Health Organization
ONG	Non-Governmental Organization
ONG	Non-Governmental Organization
CSO	Civil Society Organization
IAP	Integrated Action Plan
PARAMED	Support program for the training of paramedical personnel
PASCOB	Project to Support the Health System of Congo Brazzaville
PBDS	Biennial Health Services Development Plan

RBF	Results-Based Financing
IMCI	Integrated Management of Childhood Illnesses
HSDP II	Health Services Development Project II
EPI	Expanded Vaccination Program
FP	Family Planning
GDP	Gross Domestic Product
MPA	Minimum Package of Activities
HDP	National Health Development Plan
NHDP	National Health Services Development Plan
UNDP	United Nations Development Program
EPI	Essential packages of interventions
PTBA	Budgeted Annual Work Plan
PMTCT	Prevention of mother to child transmission
RC	Community health worker
HHR	Healthcare Human Resources
HSS	Health System Strengthening
AIW	African Immunization Week
HMIS	Health Management Information System
NHIS	National Health Information System
EmONC	Emergency Obstetrics and Neonatal Care
MCHW	Mother and Child Health Week
TBC	Tuberculosis
TD/Smear	Thick Drop/Smear
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
MCV	Anti-measles vaccine
HIV	Human Immunodeficiency Virus
WASH	Water Sanitation Hygiene

PART C– SITUATION ANALYSIS

5. Key Relevant Health and Health System Statistics

Table 1: Key Relevant Health, Immunization and Health System Statistics*:* Source: 2011-2012 EDSC-II

Indicators	Male	Female	Total
Health Indicators			
Prevalence of underweight children under the age of 5	9.9%	13.2%	11.6%
Under-five mortality rate	86‰	78‰	68‰
Infant Mortality Rate	49‰	45‰	39‰
Percentage of 1-year old children vaccinated against measles	75.3%	74.5%	74.9%
Maternal mortality ratio5	N/A	426	N/A
Immunization indicators			
Rate of BCG coverage	N/A	N/A	89.5
Rate of Penta 1 coverage	N/A	N/A	90.8
Rate of Penta 3 coverage	N/A	N/A	84.1
Rate of OPV 3 coverage	N/A	N/A	83.9
Rate of MCV coverage	N/A	N/A	77.6
Rate of TT2+ coverage	N/A	N/A	82.7
Drop-out rate from Penta 1 to Penta 3	N/A	N/A	7.6
Health system indicators			
Percentage of births attended by a trained service provider	N/A	N/A	94
Rate of contraceptive prevalence	N/A	44.7%	N/A
Percentage of women who had at least one prenatal visit	N/A	92.6%	N/A
Percentage of women who had at four or more prenatal visits	N/A	78.9%	N/A
Percentage of children under 5 whose fever was appropriately treated for malaria	24.4%	25.5%	25.0%
Unmet family planning needs	N/A	18.2%	N/A
Percentage of children under 5 sleeping under mosquito nets that have been treated with long-acting insecticide	27.4%	25.3%	26.3%

It should be noted that the EDSC-II data provide information about the immunization infrastructure before 2011, and coverage rates differentiated by gender. With the support of WHO and UNICEF, Congo recently conducted an external EPI review. The table below shows the results of the immunization coverage survey conducted for this review.

Table no. 2: proportion of children immunized, by vaccine and by gender (card and history) source: 2014 External EPI Review

GENDER	BCG	Penta3	POL3	MCV	YFV
Female	99%	88%	87%	77%	77%
Male	97%	85%	83%	78%	78%
Relative Risk	1.01	1.10	1.05	0.98	0.98

Table 3: Certain socio-economic characteristics of the under-five mortality rate in Congo. Source: 2011-2012 EDSC-II

Quotients de mortalité néonatale, post-néonatale, infantile, juvénile et infanto-juvénile pour la période des dix années ayant précédé l'enquête, selon certaines caractéristiques socio-économiques, Congo, 2011-2012

Caractéristique socioéconomique	Mortalité néonatale (NN)	Mortalité post-néonatale (PNN)[1]	Mortalité infantile (1q0)	Mortalité juvénile (4q1)	Mortalité infanto-juvénile (5q0)
Résidence					
Urbain	26	18	45	34	77
Rural	21	29	51	39	88
Département					
Kouilou	17	28	45	49	92
Niari	19	25	44	27	70
Lékoumou	24	28	52	46	95
Bouenza	29	31	60	50	107
Pool	17	24	41	31	71
Plateaux	28	29	57	39	94
Cuvette	30	27	57	39	94
Cuvette-Ouest	25	49	73	32	104
Sangha	30	45	75	47	118
Likouala	27	19	45	41	84
Brazzaville	30	18	48	32	79
Pointe-Noire	17	17	35	34	67
Niveau d'instruction de la mère					
Aucun	32	31	63	46	106
Primaire	23	31	54	41	93
Secondaire 1er cycle	25	19	44	35	77
Secondaire 2nd cycle ou plus	20	12	32	26	57
Quintiles de bien-être économique					
Le plus pauvre	22	30	52	40	89
Second	29	26	55	46	98
Moyen	24	18	42	41	81
Quatrième	26	19	46	30	74
Le plus riche	19	17	36	19	54

[1] Calculé par différence entre les taux de mortalité infantile et néonatale.

Table 4: Information on vaccines currently used and those for future use

Vaccines Currently Used by the Immunization Program		
Vaccine Product	**Year of Introduction**	**Comments** (including planned product switches, wastage etc.)
Tuberculosis vaccine (BCG)	1981	Administration at birth
Oral polio vaccine (OPV)	1981	Administration: Polio 0 at birth; Polio1 at 2 months; Polio2 at 3 months; and Polio3 at 4 months
Measles vaccine (ROUVAX)	1981	Administered between the 9th and 11th month
Tetanus Vaccine	1981	Administered to pregnant women: 1st dose upon first contact, 2nd dose 1 month later, 3rd dose 6 months after the 2nd dose, 4th dose 1 year after the 3rd dose, and 5th dose 1 year after the 4th dose.
Pentavalent (DTP-HepB-HiB)	2009	Administration: Penta 1 at 2 months; Penta 2 at 3 months; and Penta 3 at 4 months
Pneumococcus 13 (VVM 13) vaccine	2012	Administration: VVM 13 dose 1 at 2 months; VVM 13 dose 2 at 3 months; and VVM 13 dose 3 at 4 months
Yellow fever vaccine	2004	Administered between the 9th and 11th month
Hepatitis B Vaccine	2007	Since 2007, this antigen is administered at the same time as the Penta vaccine.
Rotavirus vaccine (ROTARIX)	2014	Administration: Rotarix dose 1 at 2 months; Rotarix dose 2 at 3 months
Vaccines Planned for Future Use by the Immunization Program Note: This section should include any future vaccines currently under consideration by the country and does not represent a commitment by the country to introduce the vaccines listed below.		

Vaccine Product	Month / Year of Introduction	**Comments** (including planned product switches, wastage etc.)	Plan for vaccine introduction taken into account in HSS application?
IPV 10 dose	July 2015	In November 2014, Congo's application was recommended for approval with clarifications by the IRC	Yes
Measles vaccine 2nd dose	2015	Strengthening of the cold chain, personnel training and strengthening of monitoring and evaluation mechanisms within the HSS-GAVI project are going to contribute to the success of this vaccine's introduction	Yes
Hepatitis B Vaccine at birth	2016		
Papilloma vaccine (HPV)	2017	Introduction demonstration in two departments	Yes

In Congo, the EPI has existed since 1981. According to the 2011-2012 EDSC-II, immunization coverage for the 3 doses of Pentavalent is 71.9%, and for the measles vaccine (MCV) it is 74.9%. The percentage of children who are fully immunized (children who have received all vaccines on the immunization schedule before their first birthday) is 45.5%. The percentage of children who have not received any immunizations (zero dose of any vaccine) is 3.6%.

The latest data from the 2014 coverage survey show that the actual immunization coverage for the 3 doses of Pentavalent is 86.4% and for MCV it is 77.6%. The percentage of children who are fully immunized is 75% when looking at real immunization coverages.

Whatever the data source, no gender disparity has been observed. The percentage of girls immunized (75.3%) is higher than that of boys (74.5%). However, disparities do appear when the place of residence (urban/rural per department), mother's education level and economic quintiles are considered. When looking at children who have been fully immunized, immunization coverage is lower for children whose mothers have received no formal education (40.6%) and whose mothers' education stopped at primary school (39.6%) while it is higher for mothers with at least a high school education (51.6%).
Only 38.2% of children from the poorest families were fully immunized when compared with children belong to the wealthiest families.

However, it should be noted that according to EDSC-II, the percentage of children who are fully immunized was 46% in 2011. The external EPI review conducted in 2014 showed a rate of 75%. These external review results are in agreement with those from administrative sources[7].

Lastly, the Louala department has a high rate of indigenous peoples and it is one of the departments with the lowest rate of fully immunized children (32.9%). This explains the selection of this department for the promotion of equity as does the fact that this department is difficult to access.

Table 5: Immunization based on characteristic socio-demographic criteria

[7] *External EPI Review, Congo 2014, pages 127-128*

Tableau 10.3 Vaccinations selon certaines caractéristiques sociodémographiques

Pourcentage d'enfants de 12-23 mois ayant reçu certains vaccins à n'importe quel moment avant l'enquête (selon le carnet de vaccination ou la déclaration de la mère) et pourcentage pour lesquels un carnet de vaccination a été présenté à l'enquêtrice, selon certaines caractéristiques sociodémographiques, Congo 2011-2012

Caractéristique sociodémographique	BCG	DtCoq[1] 1	DtCoq[1] 2	DtCoq[1] 3	Polio 0[2]	Polio 1	Polio 2	Polio 3	Rougeole	Tous les vaccins[3]	Aucun vaccin	Autres vaccins Fièvre Jaune	Autres vaccins Hépatite/ Hib 1[4]	Autres vaccins Hépatite/ Hib 2[4]	Autres vaccins Hépatite/ Hib 3[4]	Pourcentage avec un carnet de vaccination présenté à l'enquêtrice	Effectif d'enfants
Sexe																	
Masculin	94,5	90,4	84,4	72,3	79,5	87,5	76,6	57,6	74,5	47,5	3,0	54,2	33,2	23,8	17,8	58,4	831
Féminin	93,4	88,2	81,1	71,4	73,7	86,4	78,3	56,8	75,3	43,6	4,1	54,9	38,7	30,6	21,8	56,0	847
Rang de naissance																	
1	96,0	90,1	83,6	70,8	77,3	87,0	77,3	53,1	77,0	41,9	2,8	55,9	40,2	33,0	23,0	61,0	399
2-3	93,7	90,4	84,6	73,3	77,0	86,1	77,1	57,5	77,1	47,7	3,6	55,3	39,3	28,9	22,6	58,5	724
4-5	94,5	90,8	82,7	73,1	77,2	88,8	76,7	62,8	72,3	46,5	3,1	54,9	30,4	21,9	14,0	56,5	369
6+	89,2	79,7	73,5	66,0	71,8	86,6	80,4	54,0	67,0	42,5	6,0	48,1	25,1	19,1	13,8	44,9	185
Résidence																	
Urbain	97,4	94,4	89,3	79,9	81,2	86,9	78,4	58,5	83,6	49,3	1,7	58,1	44,9	34,3	25,6	63,9	1 022
Rural	88,6	81,2	72,4	59,3	69,3	87,0	76,0	55,3	61,3	39,7	6,5	49,0	22,2	16,2	10,8	46,6	656
Département																	
Kouilou	91,0	91,3	83,6	65,0	54,4	96,3	83,8	59,9	70,3	39,0	2,6	47,9	43,7	30,7	11,7	42,2	52
Niari	98,5	95,9	91,7	82,8	86,9	91,5	88,2	76,9	80,5	62,7	1,5	71,3	27,9	24,8	17,5	65,4	100
Lékoumou	92,1	83,5	72,9	64,0	75,9	89,1	78,0	61,5	63,1	49,1	5,7	55,5	13,5	5,1	2,8	46,8	41
Bouenza	90,8	80,1	75,0	61,1	73,8	85,9	73,4	56,3	51,1	41,8	8,3	40,9	7,7	7,7	5,4	51,4	187
Pool	91,8	86,2	83,2	78,3	87,1	89,8	82,6	66,4	79,5	59,8	4,7	73,4	12,9	5,8	4,5	69,7	107
Plateaux	72,8	60,2	47,0	27,7	45,9	80,8	65,3	35,7	41,9	14,2	11,0	31,2	22,2	12,8	8,9	25,4	68
Cuvette	96,0	89,1	76,9	64,7	76,7	84,0	75,3	57,2	75,4	43,4	3,0	66,2	44,8	37,8	31,1	52,1	67
Cuvette-Ouest	91,6	81,8	64,9	44,5	59,6	88,8	75,6	47,0	64,2	25,7	2,1	53,5	36,5	27,9	17,5	37,1	24
Sangha	93,5	69,6	62,4	48,9	68,0	88,9	77,9	44,3	52,0	31,6	2,7	18,5	27,3	22,9	14,7	37,2	27
Likouala	78,4	73,5	62,6	49,6	62,4	79,5	66,8	47,3	57,0	32,9	12,3	45,2	28,6	21,1	15,4	43,8	92
Brazzaville	96,6	94,0	87,0	79,3	80,2	81,3	72,2	49,0	81,3	37,7	2,3	56,1	45,5	35,5	26,8	57,3	512
Pointe-Noire	98,9	97,3	93,4	81,5	80,6	94,3	86,0	67,4	88,7	60,2	0,1	57,2	50,1	36,2	26,6	69,1	403
Niveau d'instruction de la mère																	
Aucun	86,1	76,5	69,1	59,6	63,5	76,5	66,1	51,9	57,8	40,6	10,1	45,2	20,5	18,0	13,4	50,2	131
Primaire	90,3	84,4	75,7	62,9	68,7	89,3	77,2	56,5	64,8	39,6	5,3	45,0	26,9	19,0	12,1	52,0	552
Secondaire 1er cycle	96,5	93,4	87,4	78,6	82,6	86,9	78,5	57,8	79,8	48,7	2,0	60,9	43,1	32,2	24,5	58,3	745
Secondaire 2ème cycle ou plus	98,6	94,3	91,3	77,9	82,9	87,2	80,6	60,1	91,5	51,6	1,0	61,4	43,0	35,2	26,4	68,7	250
Quintiles de bien-être économique																	
Le plus pauvre	86,8	78,8	69,5	56,4	65,2	85,9	75,0	54,0	58,8	38,2	6,8	47,7	22,9	17,2	11,1	41,4	381
Second	92,7	83,7	76,9	66,4	74,1	88,1	77,6	56,6	70,1	45,6	5,5	51,6	32,5	20,9	15,3	51,0	396
Moyen	96,0	94,0	88,6	74,1	80,3	88,1	75,4	55,2	80,1	42,3	1,7	56,0	38,4	26,3	21,2	57,8	327
Quatrième	99,0	97,4	90,6	85,1	83,7	89,3	83,3	63,8	84,9	55,0	0,8	61,7	43,4	37,9	26,0	69,1	313
Le plus riche	97,5	97,3	94,1	83,8	83,5	82,5	76,2	57,5	87,1	48,7	1,6	58,6	48,6	40,0	30,4	74,3	261

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6. Description of the National Health Sector

6.1. Background Information

Congo is located in Central Africa and it straddles the equator. It has an area of 342,000 km^2. It is bordered to the north by Central African Republic and Cameroon, to the south by the Angolan enclave of Cabinda, to the east by the Democratic Republic of Congo, and to the west by Gabon and the Atlantic Ocean.

The country is divided into 12 administrative departments, 87 administrative districts and 6 communes.

In 2011, the country's population was estimated at 4,085,422 inhabitants, 51.7% female. The urban population was estimated at 67.1% and the two largest cities contain 56.6% of the population (Brazzaville with 37.2% and Pointe-Noire with 19.4%)[8]. Density was estimated at 11.9 inhabitants/km^2, with a gross birth date of 41.7 per 1000.

6.2. Organization and functioning of the health system in Congo[9]

6.2.1. Administrative Structure

The health system's administrative structure in Congo has 3 levels of hierarchy: central, intermediate and peripheral.

Central Level

The central level has a strategic and prescriptive role in planning, monitoring, evaluating, coordinating, mobilizing, and allocating resources. It is represented by the cabinet of the minister responsible for health, the departments within this cabinet, and the health general directorate and 6 general departments, 3 of which were recently created by order no. 2013-813 dated 30 December 2013, focusing on the Ministry of Health and Population's organization and operations. Furthermore, the NHDP Steering Committee, the National Office for the Prevention of AIDS (CNLS in French) and its secretariat, the inter-agency coordinating committee (ICC) for immunization and vaccines and other various committees consult with and assist the ministry.

Intermediate level

This level is made up of the Health Department Directorates (HDD). They provide technical support to the health districts. The health departments follow the same lines of division as country's administrative divisions.

Peripheral level

This level is made up of health districts and health zones. It should be noted the order cited above restructured the peripheral level so that health districts geographically match up with administrative districts. As result, the country should have 111 health districts, 87 of which are rural. This reform is currently being implemented. The health committees and hospital management committees are entities for community involvement that provide support for peripheral level health system operations.

6.2.2. Operational organization of health care and services

This system is organized as a pyramid and is founded on the health district and the fundamental principles of primary health care. Health care is provided by both the public and private sectors.

8 QUIBB-ECOM 2011 analysis report, page 31
9 2015-2016 PBDS, pages 24-44

6.2.2.1. Outpatient healthcare facilities

These include public health outposts as well as clinics and private nursing services. The country has a total of 302 public outpatient health facilities[10], which include facilities in the IHCs, school-based health centers, administrative assisted living facilities and parastatal companies. The total number of personnel employed at health facilities is not known. The available data indicate that personnel numbers for each outpatient health facility vary from 50 to more than 100 in urban areas and from 1 to 4 in rural areas.
Less than 40% of health centers were involved in the process of streamlining their operations to comply with the NHDP's focus. In general, IHCs that have not been streamlined deliver incomplete packages of activities that are generally limited to curative and prenatal[11] care. It is important to note, however, that immunization is one of the most commonly present activities in packages of services that are offered by the public sector.

The survey immunization coverage data show that 14% of fixed immunization providers are private health facilities. In addition, the HERA report[12] shows that private establishments provide around 70% of clinic consultations in urban areas, and do not offer a full set of primary care services. As a result, these facilities have a significant potential for improvement as far as immunization coverage is concerned.

6.2.2.2. Hospital healthcare facilities

Hospital healthcare facilities include 6 general hospitals (GH) and 23 basic hospitals (BH). Overall capacity in the public sector was estimated at 1,945 beds in 2012. In addition to the public sector, clinics also provide hospital beds.

Significant efforts have been made to acquire and make technical equipment available to GHs. Overall, their technical capacity has been brought up to standard. However, inadequacies remain, including: (i) lack of qualified human resources, (ii) inefficient supply of medicines and medical supplies such as (iii) the maintenance of biomedical equipment. With regard to basic hospitals (BH), the technical capacities are generally inadequate and they are poorly integrated into their health districts.

6.2.2.3. Health organizations providing diagnostics and treatment

These are the National Public Health Laboratory (LNSP in French) and the National Blood Transfusion Center (CNTS in French), two public organizations that are legal entities and are financially independent. The LNSP has the equipment required for quality, specialized high-level medical tests and meets international standards. The CNTS is responsible for collecting, preparing, categorizing and distributing blood products to health care facilities.

6.2.2.4. HIV/AIDS outpatient treatment centers and tuberculosis treatment centers

The country currently has three HIV/AIDS outpatient treatment centers and two tuberculosis treatment centers located, respectively, in Brazzaville and Pointe Noire. These centers are subject to specific regulations. The operate independently from the health districts in which they are located.

6.2.2.5. Programs and projects

Today, there are 11 specific programs and projects dedicated to various health care priorities. All these programs and projects are based on national and global strategies. The activities of most of these specific programs are meant to be carried out at the operational level.

In 2008, Congo adopted a roadmap to accelerate the reduction of maternal, neonatal and child mortality[13]

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10 *2015-2016 PBDS, Ministry of Health and Population; 2014.*
11 *2015-2016 PBDS, Ministry of Health and Population; 2014, page 25*
12 "Study on private health sector in Republic of Congo," Health Research for Action, HERA 2011: https://books.google.cg/books?id=4hIrb2bVqDMC&printsec=frontcover&hl=fr#v=onepage&q&f=false
13 National roadmap to accelerate the reduction of maternal, neonatal and child mortality

for the 2010 to 2015 period. In addition, the integrated management of childhood strategy has been in place since 2009.

6.3. Healthcare service performance in Congo

According to the EDSC-II, high levels of prenatal visits (93%)[14] and births assisted by qualified personnel (92%) have been observed in Congo. These indicators contrast with the real scope of maternal and neonatal mortality. This observation reveals inadequate quality of prenatal consultations and childbirth management.

Related to this lack of quality, the available data show that 28% of users are dissatisfied with health services. This rate of dissatisfaction reaches 52% in certain departments. By order of importance, the main of this dissatisfaction are: (i) the high cost of services, (ii) long wait times, (iii) poor welcome, (iv) ineffective treatment, (v) the lack of trained personnel and (vi) frequent drug inventory shortages.

In addition, the usage rate for health care services offered by the IHCs is relatively low[15], limited to 24%; curative consultations are less than 0.5 contacts per year per inhabitant. The main factors limiting usage are difficult geographic and financial access as well as frequent supply shortages. These limits are seen more often in rural areas and within disadvantaged groups in the population, especially among indigenous peoples and poor families.

The current poor performance of health services is also a result of the fragile nature of the inadequacies observed in health district operations. These are mainly: (i) deficiencies in the supervision of IHC teams (ii) these team's lack of technical abilities (iii) the under-funding of planning activities and M&E; (iv) the inadequacies of the national health information system (NHIS) and (v) various logistical constraints such as the lack of supervision vehicles that impedes the development of mobile and outreach strategies. These constraints have an immediate impact on access to essential packages of services, including immunization.

In addition, the lack of participation by communities, or failure of community entities to participate, as well as the lack of consensus on packages of activities by community health workers and their motivations, result in, among other issues, weak community involvement and limited use of health care and services available in the health districts.

The analysis of bottlenecks affecting the health system in Congo that was detailed in section 9 highlights the inadequacies and dysfunctional nature of the 6 main principles of a health system, which are: system governance, service offerings, funding, human resources, medicines, vaccines, and health information and technology.

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14 EDSC-II 2011- 2012; page 13
15 ECOM 2011, page 9

7. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

During the 2007-2011 NHDP implementation, the MPH was provided with the Biennial Health Services Development Plan (PBDS in French) 2015-2016, along with the 2012-2016 National Health Development Plan (NHDP). It should be noted that an overall health sector review did not occur before the 2015-2016 PBDS was drafted. The PBDS serves as a reference for the implementation of a health policy in Congo.

This program targets the reduction of morbidity and mortality between now and the end of 2016. More specifically, the goal is to reduce: (i) maternal mortality from 426 to 407 deaths per 100,000 live births; (ii) neonatal mortality from 22 to 18 deaths per 1,000 live births; (iii) under-five mortality from 68 to 52 deaths per 1,000 live births; (iv) incidence/prevalence of HIV/AIDS, malaria and tuberculosis, other transmissible and non-transmissible diseases, and (v) the prevalence neglected tropical diseases and vaccine-preventable illnesses.

Attaining these objectives is linked to the 11 strategic orientations that are part of the health system strengthening process. These orientations mainly address improved governance and health service management capacity; improved coverage for the population of quality essential care and services, including hygiene services; improved equity with regard to access to packages of essential care and services; and, the promotion of the community approach to organizing the essential care and services provided in the health districts. Due to its strategic orientation, the 2015-2016 PBDS outlines plans to have at least 70% of health centers, basic hospitals and other health facilities offer full and quality packages of care, in compliance with defined standards. In addition, the targets indicated for use of health services by the various populations and the rates of coverage for public health program services, especially the EPI, should be attained in at least 80% of the health districts.

Concerning immunization, the main lines of action defined in the 2015-2016 PBDS[16] include: (i) making immunization funding sustainable, (ii) integrating immunization into all outpatient health facilities, both public and private, (iii) the pursuit and strengthening of the integration process for new vaccines into the EPI routine, (iv) the effective implementation of the RED strategy, (v) bring the cold chain up to standard and having it properly maintained throughout the country, (vi) improving injection safety, (vii) organizing care of adverse events following immunization (AEFI) and supplementary immunization activities (SIA).

The promotion of the community approach to organizing essential care and services in the health districts will be accomplished by: (i) developing and implementing a strategy that defines the package of services for the community level, the modalities and resources required for implementation, (ii) the implementation of an appropriate legal framework for community health workers and (iii) the development of monitoring and evaluation mechanisms for use with community health workers.

For 2015, a mid-term review will be conducted to assess the levels of execution of different activities for various interventions, as well as the degree to which targeted outcomes have been attained for the 2015-2016 PBDS. Since the 2015-2016 PBDS is the only reference for implementation of a national health policy, a one-time sector review involving all participants should be conducted by the participating parties[17]. The GAVI Alliance will be involved in preparing and conducting the sector review planned for 2015 which will be the first such review conducted in Congo.

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[16] *2015-2016 PBDS, page 56*

[17] C*f. 2015-2016 PBDS, page 94*

8. Monitoring and Evaluation Plan for the National Health Plan

Chapter 7 of the 2015-2016 PBDS plans for an implementation and monitoring and evaluation (pages 90-96) that depend on an operational NHIS for data collection, treatment and analysis. Related to the monitoring plan, there will be monthly supervision by the health districts of the IHCs, quarterly supervision of the health district senior management teams by the health department directorates, and quarterly supervision of the health department directorates by the central level.

The operations described in the budgeted annual work plans (referred to as PTAB in French) will be the main reference for regular monitoring of program implementation. Accordingly, a monthly monitoring meeting involving those managing the health centers and basis hospitals will be organized in each health district. Furthermore, each department director will organize a quarterly meeting with the health district senior management teams.

These meetings will address: (i) the progress review conducted through periodic report review; (ii) the identification of problems that arise during the period and (iii) discussion about corrective action and related decisions. Related to this, the 2015-2016 PBDS defines each outcome sought, the main monitoring indicators and the modalities for their use.

The annual review planned for 2015 should: (i) ensure adequate implementation of activities, (ii) guarantee consistency and complementarity of services undertaken by the different participants; (iii) identify possible gaps and (iv) formulate recommendations to correct the situation if needed. From a methodology perspective, the process will include reviews conducted in the health districts as well as in the country's 12 departments.

There will be an entirely separate review of the health sector focused on preparatory work and a meeting involving government representatives, technical and financial partners, and representatives from civil societies. The preparatory work for the sector review will not only include the compilation of summary reports from the different levels, but also joint field mission visits, to have a better understanding of progress that has been made. Completed monitoring indicators from certain evaluation indicators will be used for the sector review.

A final evaluation will be conducted in 2016. It will focus primarily on assessing to what degree targeted objectives have been attained, and the expected outcomes for the program. It will include an external evaluation and a user satisfaction survey. At the beginning of the monitoring, the 2015-2016 PBDS defines each outcome sought, the main evaluation indicators and the modalities for their use.

No evaluation of national strategy has been conducted jointly by all participating parties. At the same time, the 2015-2016 PBDS plans for a one-time sector review to be conducted in 2015, as part of the mid-term review.

It should be noted that immunization data are collected at fixed immunization centers using standard supplies. The reports produced after data processing and analysis are submitted at all levels on a monthly basis. At each level, data monitoring is carried out and corrective action is taken. Ever month, the program produces a global report and shares it with local and international partners. The main indicators being monitored are: immunization coverage per vaccine; Penta1/Penta 3 and BCG/MCV drop-out rate, percentage of HDs with Penta3 immunization coverage of >80%; number of children not vaccinated with Penta3 and MCV; wastage rate per vaccine.
Every three to four years, the country, with the support of partners, conducts coverage surveys at the national level (EDS, External EPI Review). For example, an external review was carried out in 2014 and the next one is scheduled for 2017.

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9. Health Systems Bottlenecks to Achieving Immunization Outcomes

During the factual analysis of the health situation performed during 2015-2016 PBDS[18], 2012-2016 cMYP[19], 2014 External EPI Report[20], a number of bottlenecks limiting health service performance were identified. The factors that directly impede the successful development of the country's immunization system are summarized below:

9.1. Health services governance

The governance of health services is marked by:

- the lack of a legal framework: lapses in certain texts, lack of applicable texts for certain orders and laws;
- inadequate hierarchical positioning of the EPI management structure;.
- weak support provided to health districts by the health departmental directorates, including lack of support for immunization program management;
- inadequacies observed during development, implementation, monitoring and evaluation of health policies, strategies, plans and programs;
- poor coordination of health sector services;
- the fact that reviews and evaluations of sector services are not systematic;
- weak participation of non-institutional participants (civil society, private sector, communities) in planning, implementation and evaluation of health activities, including immunization

9.2. Health care and services provided

The health care and services provided are marked by weak coverage and poor quality. There have been strong inequities observed, specifically for marginalized populations and especially for indigenous peoples. This situation is due to several factors: (i) lack of IHC coverage throughout the country; (ii) lack of competent human resources, (iii) constraints related to the supply and distribution of essential medicines; (iv) poor logistical support.

Around 80% of health districts function at a very low level. Their senior teams are incomplete and untrained in health management and their IHCs are not committed to streamlining operations. The lack of the integration of immunization activities into the essential packages of services offered by certain public health centers is revealing.

9.3. Demand and use of health services

The demand for health care and services is insufficient due to: (i) the lack of activities promoting health; (ii) weak development of community approaches (home visits, catch-up for immunization drop-outs, etc.); (iii) the offer's poor quality, with, among others consequences, dissatisfied users and (iv) the lack of specific approaches being implemented to stimulate demand for care and services by users. For example, there is a lack of inter-personnel communication from the IHCs about essential packages of services, a lack of mass communication, and a lack of the dissemination of messages through both traditional and modern channels of communication (new information technologies).

Diverse factors converge with low use by the various populations of health care and services. These factors are mainly: (i) the poor welcome that users receive; (ii) discontinuities in care provided to users; (iii) frequent shortages of medicines, vaccines and other supplies and (iv) the high cost of care and services, in contrast with the various populations' levels of poverty.

9.4. Healthcare funding

In Congo, healthcare funding is still inadequate due to how it is distributed and to insufficient budget

[18] *2015-2016 Biennial Health Services Development Plan, pages 47 - 50*

[19] *2012-2016 Comprehensive Multi-Year Plan, pages 15-30*

[20] *October 2014 External EPI Review*

allocations. According to the national health accounts for 2009 and 2010, healthcare expenditures were mainly funded by the government (58%) and households (39%). The allocations were given in priority to central level facilities and to GHs (75%); very few resources were allocated to peripheral facilities (7%) or specific programs (14%)[21]. This situation can partly be explained by the poor implementation of operational level activities, such as supervision and outreach strategies.

9.5. Human resources

Poor quality management and the lack of rational use of human resources is a serious bottleneck to providing essential packages of services. In fact, the census data on health services employees in 2011 show that, overall, Congo has a significant number of health personnel, but there is also significant dysfunction and human resources management has multiple inadequacies: lack of a plan for developing consistent human resources, and the lack of appropriate tools such as job standards and job descriptions, etc. being used. Due to this, several rural health centers and outposts are staffed by community health workers who have little training in providing essential packages of services, including immunization. Furthermore, others are closed due to a lack of personnel. Furthermore, the problems with the healthcare workforce and the poor quality of health district management by the senior teams have a direct impact on support and supervision.

9.6. Medicines, medical products cold chain equipment and other logistical issues

Here, the situation is characterized by: (i) limited availability of medicines and medical products; (ii) the obsolete nature of medical equipment; (iii) the obsolete nature of cold chain equipment in the HDDs, health districts and health centers[22]; (iv) the lack of efficient vaccine management and (v) recurring vaccine and injection supply shortages.

In addition to a lack of infrastructure, equipment and technical machinery, health districts do not have supervisory vehicles.

9.7. Health information system

The health information system is characterized by inadequacies as well as facts being used very little to guide in decision making.

This situation is the result of inadequate development of the National Health Information System (NHIS), despite actions currently being taken. This can be attributed to several factors, specifically: (i) the lack of texts about the NHIS, how it is organized, how it operates, its features and its procedures; (ii) the low level of approval and involvement of key NHIS stakeholders; (iii) low technical competence as related to the collection, treatment, and analysis of data, report creation and use of results and (iv) the inadequate use of the budget allocated to NHIS development. The inadequacies shown by the routine EPI data reveal these weaknesses.

9.8. Partnerships and community involvement

The 2015-2016 PBDS notes that only 26% of health districts have a functional health committee. Although 79.7% of IHCs have created a health committee, none of these have satisfied the criteria for having a *functional* committee. This poor level of community involvement via these management entities could be one of the explanatory factors for the reduction in the use of health services by the community. It has gone from 26.7% in 2005 to 23.8% in 2011[23]
Problems related to partnerships and community participation are: (i) the low level of health actions carried out at the community level and the lack of effective participation of local participants as well as the lack of a

21 National Health Accounts, 2009-2010, MPH, 2012, pages 20 to 22
22 cMYP pages 26-27
23 2015-2016 PBDS, page 45

public-private partnership, including civil society organizations; (ii) weak coordination of various partners by the Ministry of Health; (iii) inter-sector collaboration that functions at a very low level and (iv) very limited capacity for monitoring partnerships and inter-sector cooperative programs.

9.9. Specific bottlenecks that will be removed as a result of GAVI funding

In a very specific way, the contribution of the HSS-GAVI funding will play a determining factor in removing the bottlenecks described below:

- inadequacies and inequities with the offer and use of a high-quality package of essential services, including immunization, specifically for marginalized populations and indigenous peoples;
- lack of demand for essential packages of services, and, in particular, lack of demand for immunization services;
- lack of planning and supervision and lack of a system for monitoring and evaluating immunization activities;
- lack of a logistical chain and lack of efficient vaccine management;
- health workers' poor technical competence in matters related to immunization;
- inadequate logistical methods to supervise the health districts; and
- poor coordination of services, partnerships and community and CSO involvement, as well as poor private sector participation.

FOUR PAGES MAXIMUM

10. Lessons Learned and Past Experience	
Objectives	**Lessons learned, highlighting both successes and challenges; include any lessons learned from grant implementation**
Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.	• Experience from the project to strengthen the health system in Congo Brazzaville (referred to as PASCOB in French) from 2004 to 2009 resulted in the revitalization of 5 health districts by focusing on their services and on the renovation of health infrastructure (ICHs and locations with senior teams), the training of senior teams in these districts, the strengthening of the Minimum Package of Activities, including immunization and regular, high-quality supervision, community participation and the supply of medications. • During this period, Congo has defined and launched the implementation of essential packages of services at the community level, in health centers and hospitals. These services have contributed to reducing the current maternal and under-five mortality rate[24]. • The implementation of the performance-based funding (PBF) pilot[25] was successful. It was carried out in three departments (Pool, Plateaux and Niari) and served as the basis for HSDP II, which plans to expand PBF into seven departments. • Learning from these experiences, the emphasis will be placed on improving the availability and quality of the essential packages of services offered, thanks to the HSS-GAVI support.
Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.	• ISS-GAVI support between 2004 and 2011 improved immunization coverage for penta 3 from 44% in 2002 to 88% in 2011 throughout the country; • similarly, from 2009 to 2014, support from the ENI Foundation for the implementation of RED components in three departments (Kouilou, Niari and Cuvette) lead to attaining and maintaining good immunization coverage in the departments noted above; • as a result, HSS-GAVI support will be used to scale the RED approach to the selected health districts.
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.	• Providing 10 health districts with computer kits and training them in NHIS data management led to an improvement in report completeness and generated the 2012 statistics yearbook, twenty years after it had been last published. • The poor quality of data produced by the routine system explains the disparities observed between administrative data and that from WHO/UNICEF surveys/estimates. • NHIS capacity is still inadequate: the routine data produced are generally fragmented and unreliable and surveys are infrequent. The decision makers do not always have factual bases for making decisions at either the strategic or operational level. • HSS-GAVI support will allow for: (i) reinforcing of health district capacity so that the HDs can produce high-quality data and submit the periodic reports required and (ii) implementing various mechanisms for validating data, including DQA.

24 LIST analysis tool
25 HSDP-II, page 31

Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.	• One of the items that remains to be implemented to make IHCs more efficient is scheduling. Using them to monitor the use of routine services has been shown to be very efficient in rural areas, but less so in urban ones. This also affects the persistently weak service coverage in urban areas, since there is no system being used to catch-up with immunization drop-outs. • The mobile telephone penetration rate in Congo is very high (92%) in urban areas and the successful experience transmitting SMS messages about health programs like the "yellow line" and the third round of the polio campaign will enable a growth strategy for the demand and use of services (including the essential package of services and immunization). • Therefore, the use of mobile telephone technology is an appropriate response that will contribute to minimizing the limits of manual scheduling. This will entail, thanks to support from HSS-GAVI, generating an electronic schedule and reminder messages which will then be disseminated to the mobile phones of the parents of children who are scheduled for immunization.
Objective no. 5: From now until the project is complete, strengthen governance and program management.	• Several service coordination committees exist within the health system, including the ICC which approves and validates policies and results from the implementation of immunization activities. • At the intermediary and peripheral levels, there are coordination committees that exist on paper, but lack expertise and leadership; HSS-GAVI will strengthen these entities. • The EPI occupies an administrative service position within the General Directorate of Population. It is made up of six sections. Considering the immunization challenges the country faces and the significant amount of resources that are allocated to immunization efforts, it is important that the EPI have the same level of authority as a central directorate. In addition, it management structure should be improved so that the EPI can efficiently carry out the technical, management and administrative tasks that are assigned to it. This restructuring will occur in tandem with the strengthening of the EPI's management team's management capacity.
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PART D — PROPOSAL DETAILS

11. Objectives of the Proposal

Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.

This objective complies with the expected outcome for the no. 2 objective of the 2015-2016 PBDS. It will be reached by: (i) the renovation/repairs to the buildings of the 20 operating health centers as needed; (ii) providing 60 IHCs with equipment and technical materials, (iii) providing management tools for activities including instructions and guidelines for their use; (iv) organizing training / retraining sessions for senior staff on health district management; (v) the development and distribution of the manual for worker supervision and activity coverage monitoring in the health districts; (vi) organizing monitoring sessions about coverage for essential packages of services, especially immunization coverage in the health care zones (organizing community assemblies); (vii) organizing monitoring sessions about coverage for essential packages of services, especially immunization coverage in the health districts; (viii) organizing monthly supervision of IHC workers by senior staff; (ix) organizing quarterly supervisory missions of the health districts by the HDDs; (x) organizing quarterly supervisory missions of the HDDs by the central EPI office.

Improved health coverage in the districts with poor performance will accelerate the introduction of performance-based funding, being that 7 of these poorly performing districts are part of the HSDP II intervention zone. These health districts will benefit from financial incentives for obtaining better results, including results related to immunization.

Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.

Increasing the percentage of children who are fully immunized is an objective that is included in the cMYP as is the goal of improving immunization coverage and a strategic orientation centered on improving the services offered to[26] marginalized groups and their coverage.
To reach this objective, the HSS-GAVI project activities will be focused on the services provided as well as the demand for immunization services. With regard to the services provided, the following are planned: (i) provide 60 IHCs with motorbikes for supervision and outreach and mobile strategies; (ii) provide every IHC with 4 bicycles for outreach strategies and supervision community health workers; (iii) provide the central EPI office and the HDs with vehicles/out board motor boats for supervision and mobile strategy; (iv) provide the support needed to organize outreach and mobile strategies in health districts, and, specifically, to reach indigenous peoples; (v) organize campaigns to offer essential packages of services, including immunization of indigenous populations and those who live on rivers; (vi) conduct an EVM in 2015; (vii) for those involved in EPI at the central and HDD levels, organize EPI training sessions on EPI management, planning, program M&E, vaccine and cold chain equipment management, and EPI data management; (viii) train senior staff at 9 health districts and nurses at 60 of the IHCs on MLM and EPI management; (ix) provide 40 IHCs with solar and electric cold chain equipment (x) regularly verify vaccine and other EPI input transport from the central level to the centers.

Regarding demand, it will be necessary to intensify activities related to improving the service usage rate, with specific focus on immunization.[27] In addition, appropriate strategies and approaches will be used to reach marginalized populations, and especially indigenous peoples. These are: (i) train 2 agents per health district on cold chain equipment maintenance; (ii) develop and implement communication plans about

[26] *2012-2016 cMYP, page 57*
[27] *2012-2016 cMYP, page 59*

routine immunization and the delivery of the package of high-impact services to poorly performing health districts; (iii) advocate for a budget allocation[28] for the maintenance of cold chain equipment, motorbikes and vehicles.

Objective 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.

This objective is included in the 2015-2016 PBDS strategic orientations related to NHIS strengthening[29]. Within this context, this means to: (i) provide the HDDs and health districts with computer equipment and modems to process and submit NHIS data; (ii) provide support for the electronic entry and processing of NHIS data; (iii) train NHIS data managers on the use of standard tools, collection methods and techniques as well as data processing and analysis; (iv) organize twice-yearly self-evaluation and quality audits of the data provided by the IHCs (DQS and DQA); (v) organize immunization coverage surveys in 2018; (vi) organize the internal and external evaluation HSS-GAVI program at mid-way through the project and at its completion.

At a global level, a periodic review of the health sector will be instituted. To this end, support for health sector evaluations in general and immunization evaluations specifically at the national, departmental and district level will be key to being able to follow the progress that has been accomplished. Finally, immunization coverage surveys will be carried out every two years to assess the actual level of immunization coverage, supplementing the routine data and that of other surveys (EDS, MICS).

Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.

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For these strategic orientations related to promoting community participation, the 2015-2016 PBDS recommends ensuring "better information for populations about essential packages of interventions that are offered by health facilities[30]." Therefore, this will mainly include: (i) undertaking negotiations with mobile telephone companies about the use of their networks and mobile phones to promote immunization; (ii) organizing the official signing ceremony for the partner agreement with the mobile phone operators; (iii) acquiring the computer equipment required to ensure the development and distribution of electronic schedules and other applications on the mobile phones belonging to the parents of children registered for immunization; (iv) ensuring the implementation of the application of mobile phones: the development and distribution of electronic scheduling, the cost of voice calls and automatic SMS messages to the target population. (v) holding a development workshop for community mobilization support materials (banners, posters, bibs, T-shirts, caps, radio television spots on "Gestes qui Sauvent" ("Gestures that Save")); (vi) identifying and training at least 2,400 community health workers on locating drop-outs and on when they are not located, the implementation of the essential packages of services and immunization activities, message delivery, conducting home visits and promoting health; (vii) providing community health workers with the awareness raising and visibility tools required to carry out these activities;(xvi) training health committee members on PHC, the role of the health committees, operations and management for community health care; (viii) organizing mass awareness-raising sessions and home visits; (ix) counting households in health zones and (x) organizing monthly supervision of community health workers by the senior IHC staff.

The implementation of community strategies will be based on the opportunities detailed in order no. 2013-280 dated 25 June 2013 that addresses community organization via community health management committees (CHMC). These committees will work within a multi-sector context and have a certain number of advantages, including Government grants. Related to this, a workshop on consensus in community strategies will be organized.

[28] *2012-2016 cMYP, page 59*

[29] *2015-2016 PBDS, page 64*

[30] *2015-2016 PBDS, page 66*

Objective no. 5: From now until the project is complete, strengthen governance and program management.

Strengthening governance and steering of the health system is also a leading strategic orientation in the 2015-2016 PBDS[31]. With regard to the EPI, the following are planned: (i) advocate for restructuring of the EPI management approach, provide the EPI with additional supplemental technical personnel and give it the same status and authority as a central directorate along with appropriate funding; (ii) provide EPI management with appropriate management tools; (iii) support the ICC.

Focused on strengthening the health system to sustainably improve immunization coverage, this project targets health districts that meet the following criteria: (i) low immunization coverage - less than 80% - in Pentavalent 3 and MCV, (ii) low or average immunization service usage rate, and (iii) recent epidemic. In applying these criteria, 7 health districts were selected in 5 of the country's 12 departments. These health districts represent a total population of 1,517,289 inhabitants which is more than one-third of the entire population in Congo. Three of the districts are located in zones that are difficult to access due to rivers or forests. In addition, these HDs have indigenous populations.
These HDs have a total of around 60 IHCs that benefit from HSS-GAVI support, 20 of which require renovation work to make them functional. 40 of these IHCs should receive updated cold chain equipment.

Table 6: Health districts selected for the HSS-GAVI Project, January 2015

Department	Health districts	Population	Penta 3 IC	MCV IC	Utilization rate	Epidemic situation	Comments
Brazzaville	Moungali	199,425	76%	67%	Low	+-	Measles epidemic 2012
	Ouenzé	217,526	79%	58%	Low	+-	Measles epidemic 2012
	Talangai	404,151	57%	45%	Low	++	Measles epidemic 2012
Bouenza	Nkayi	140,333	66%	65%	Medium	++	Measles epidemic 2011-2012
Cuvette*	Owando	186,435	86%	90%	Good	+	Measles epidemic 2012
Likouala	Impfondo	184,068	64%	55%	Low	+++	Cholera and measles epidemic 2012-2013
Pool	Kinkala-Boko	185,351	73%	79%	Medium	++	Measles epidemic 2012-2013
Total	**7**	**1,517,289**					

Note: Penta 3 and MCV immunization coverages correspond to the January-December 2013 period

(*) the withdrawal of support from the ENI Foundation is a threat to the maintaining vaccination performance.

TWO PAGES MAXIMUM

[31] *2015-2016 PBDS, page 63*

12. Description of Activities	
Objectives / Activity	**Explanation of link to improving immunization outcomes**
Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.	
1.1. Renovate/repair the buildings of the 20 operating health centers as needed	On average, 20% of health center buildings currently require renovation work, that if not completed, preclude the centers from offering a high-quality essential package of services, immunization or other activities
1.2. Draft integrated micro-plans using bottleneck analysis results from the 84 health zones	The point of departure for improving performance is to create a good plan of action that is adapted to local realities to correct inequities in the use of services.
Draft integrated micro-plans using bottleneck analysis results from the 7 health districts	During this process, each health district will have an integrated operational plan for which the activities will target improving immunization coverage.
1.4. Provide 40 IHCs with equipment and technical materials	These acquisitions are required due to the total lack of equipment in the IHCs and the obsolete nature of any equipment that does exist.
1.5. In the 84 IHCs, implement management tools for activities including instructions and guidelines for using them.	The availability of management tools for activities and the application of instructions and technical guidelines are indispensable to ensure quality and facilitate data being reported in a timely.
1.6- Organize 7 training sessions (1 per HD) for HD senior staff members and IHC nurses on the implementation of the essential package of interventions, community activities, conducting supervisory and monitoring meetings	In addition to training on EPI, the training on the essential packages of services will lead to improved quality of the services provided and better guarantee their use
1.7. Develop and distribute the manual for worker supervision and activity coverage monitoring in the health districts. .	This will entail having a single reference manual for supportive supervision and monitoring of essential package of service coverage, including immunization, which is considered to be an entry into being able to strengthen the health system.
1.8. Organize the monitoring sessions for essential packages of service coverage, specifically immunization coverage for all health zones (organization of community assemblies)	Monitoring coverage exercises offer the opportunity for the health teams to organize observation discussion meetings with community representatives
1.9. Organize the monitoring sessions for essential packages of service coverage, specifically immunization coverage for all health districts	These exercises include calculating monitoring indicators, their graphical representation, and review meetings for observations by the health teams with community representatives.
1.10. Organize monthly supervisory missions by the HDs of the IHCs	These supervisions strengthen the workers skills and, consequently, improve IHC and health outpost performance
1.11. Organize quarterly supervisory missions by the HDDs of the HDs	Supervision by the HDDs of the HDs allows for global strengthening of the senior staff's capacities.
1.12. Organize monthly supervisions of community health workers by the IHCs	Supervision by the EPI central office of the HDDs allows for global strengthening of the HDD staff's capacities.
1.13. Organize 18 twice-yearly supervisory missions by the EPI central office of the HDDs.	These are key to strengthening the community health worker's capacities.
Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.	

12. Description of Activities	
Objectives / Activity	**Explanation of link to improving immunization outcomes**
2.1. Provide 5 HDs with 15 HP outboard motor boats for supervisory activities and mobile strategy	Providing the IHCs with necessary equipment is crucial for the success of outreach and mobile strategies and the supervision of community health workers.
2.2. Provide 84 IHCs with motorbikes for mobile and outreach strategies	Bicycles are meant for the use of community health workers to facilitate their mobility.
2.3. Provide the EPI central office and 7 HDs with vehicles for supervisory activities and mobile strategy	Providing the health districts with necessary equipment is crucial for the success of outreach and mobile strategies and the supervision of IHC workers.
2.4 Provide 84 IHCs with four bicycles for outreach strategies and the supervision of community health workers	Providing the health districts with necessary equipment is crucial for the success of outreach and mobile strategies and the supervision of IHC workers.
2.5. Provide the support required to organize outreach and mobile strategies in health districts, particularly for accessing indigenous peoples.	Mobile strategies will be organized more carefully to reach populations in areas that are difficult to access, particularly indigenous peoples.
2.6. Organize campaigns offering essential packages of services, including immunization, for indigenous peoples and those who live on rivers.	The campaigns for access to the essential packages of services were conducted with the support of UNICEF for indigenous populations and those who live on rivers, who are difficult to access via land routes.
2.7. Organize training sessions on EPI management, planning, program M&E, vaccine management, cold chain equipment management, and EPI data management for those involved in the EPI at the central level and in the HDDs.	These training sessions will strengthen technical competence of participants involved in EPI management at the central and in the departments.
2.8. Train senior staff at 7 HDs and nurses at IHCs on MLM and EPI program management.	In the last 5 years, the senior HD staff has not received training in MLM or EPI management. This will strengthen their technical competence and improve their performance in this domain.
2.9- Provide 40 IHCs with solar and electric cold chain equipment.	The procurement of refrigerators is required for at least half of the IHCs. The decision has been made to procure solar and electric refrigerators. These acquisitions are part of the plan to renovate the cold chain32.
2.10. Regularly verify vaccine and other EPI input transport from the central level to the centers.	This involves advocating for timely co-financing, and to finance the acquisition of routine vaccines as well as a sufficient number of campaigns.
2.11. Train 2 workers per health district on the maintenance of cold chain equipment.	In compliance with the 2011-2015 cold chain maintenance plan33, the EPI has trained 805 health workers on preventive maintenance at all levels. The EPI has a pool of technicians at the central and intermediate levels who work on installation and maintenance for solar equipment. HSS-GAVI support will be in addition to this.
2.12. Develop and implement communication plans for routine vaccination and the delivery of the high-impact package of services in the 7 health districts who perform poorly	Each health district has its own issues and specific problems. Adapted communication plans will be developed while keeping these specific issues in mind.

[32] *Cold Chain Renovation Plan - August 2012*

[33] *2011-2015 Maintenance Plan, pages 16-17*

12. Description of Activities	
Objectives / Activity	**Explanation of link to improving immunization outcomes**
2.13. Conduct advocacy for a budgetary allocation designated for the maintenance of cold chain materials, motorbikes and vehicles	Partner efforts for the acquisition of the logistical means needed will be accompanied by the government's contribution which should provide the facilities with budget line items that are sufficient to ensure maintenance
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.	
3.1. Provide 7 health districts with computer kits and modems to process and submit NHIS data	The computerization of the NHIS will improve data management for the essential packages of services, including immunization.
3.2. Provide electronic entry and processing support for NHIS data.	This integrated support was designed for data entry and processing as related to the implementation of the essential packages of services, including immunization. Making it available to all will contribute a noticeable improvement in the quality of routine EPI data.
3.3. Train those who work with NHIS at the 7 HDs on collection methods and techniques, as well as data processing and analysis	Training data managers will facilitate the understanding of the tools used and, as a consequence, the creation of quality data.
3.4. Twice a year, organize self-assessments and data quality audits of data provided by the IHCs (DQS and DQA)	The DQS and DQA have mechanisms to ensure the quality of the coverage data submitted
3.5. Organize the immunization coverage survey for the 4th quarter of 2017	The immunization coverage surveys will allow for an objective analysis of if the program is leading to improved immunization indicators.
3.6. Organize the evaluation of the GAVI-HSS program at mid-point and upon its completion	Useful information will be available to show the program's impact and help guide services.
Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.	
4.1. Organize a workshop to develop support materials for community mobilization (banners, posters, bibs, T-shirts, caps, radio and television spots on "Gestes qui sauvent" ("Gestures that Save")).	Standardized tools will lead to improved community mobilization with the goal of increasing the demand for health care and services.
4.2. Identify and train at least 840 community health workers on locating drop-outs and on when they are not located, the implementation of the essential packages of services and immunization activities, message delivery, home visits and the promotion of health.	This training is key to giving the community health workers the basis for communication during home visits
4.3. Provide community health workers with the tools to raise awareness and the visibility required to conduct their activities.	The community health workers who have been trained should be provided with the support necessary to do their work.
4.4. Train members of the 84 health committees on the role, operations and management of community health care	This training is key to helping health committee members properly serve in that role.
4.5. Organize mass awareness-raising sessions.	This includes mass awareness-raising campaigns which will be complementary to the work carried out by the community health workers.

12. Description of Activities	
Objectives / Activity	**Explanation of link to improving immunization outcomes**
4.6. Organize home visits in the health zones targeted for intervention.	Home visits are key to the set of activities carried out by the community health workers to raise awareness and ensure acceptance by the community
4.7. Ensure that the counting of households in the health zones is organized by community health workers	The results from this counting will be used to determine the numbers of people in the populations targeted for these activities.
4.8. Undertake negotiations with mobile telephone companies to use their networks and mobile phones to promote immunization	Meetings with the two main telecommunications companies will lead to finalizing an agreement for their participation in the project
4.9. Organize the official signing ceremony for the partner agreement with the mobile phone operators	This official ceremony needs to be a major awareness-raising event for decision-makers and the general public about the challenges and issues facing immunization in Congo.
4.10 Acquire the computerized equipment required to ensure the development and distribution of electronic schedules and other applications on the mobile phones of the parents of children registered for immunization: Purchase the server and features.	This will be accomplished by the acquisition of a server, the development of computer programs and user training
4.11. Ensure the implementation of the mobile phone application	These activities dedicated exclusively to immunization should have an immediate effect on reducing the drop-out rate.
Objective no. 5: From now until the project is complete, strengthen governance and program management.	
5.1. Advocate for restructuring of EPI's approach to management, provide EPI with additional supplemental technical personnel and give it the same status and authority as a central directorate as well as appropriate funding;	The expected restructuring and additional human resources should have an immediate impact on program management related to administrative and technical issues, including the support to be provided at the operational level.
5.2. Provide EPI management with appropriate management tools	This is mostly referring to electronic vaccine inventory management tools, cold chain equipment, as well as immunization databases and equipment.
5.3. Support the NHDP steering committee and the ICC	This support should lead to rejuvenating not only the NHDP and its technical committee, but also the ICC so that it meets more regularly and is more efficient.
5.4. Ensure that the national technical immunization advisory group is well implemented and operational	The implementation of this structure will assist the EPI with immunization
5.5. UNICEF and WHO technical support	In UNICEF's role as an implementation partner, it is expected to provide quality technical support to help reach target outcomes.

13. Results Chain

Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.

Key activities:	Intermediate Results:	Immunization outcomes:
Renovate/repair and provide IHCs with basic medical/technical equipment and material	Renovated and equipped IHCs are likely to offer quality essential packages of interventions, including immunization	Immunization coverage is improved on an equal basis in each health zone
Organize training sessions or retraining sessions for senior staff in the IHCs health district management, within the context of PHC.	The capacities of senior staff and health workers in the IHCs are strengthened with regard to organizing and managing essential packages of interventions, including immunization	
Organize periodic supervisions as well as monitoring sessions for essential packages of service coverage, specifically immunization coverage for all health districts.	IHC performance in offering essential packages of interventions are regularly reviewed as are corrective action taken.	
Related Key Activities Indicators:	**Related Intermediate Results Indicators:**	**Related Immunization Results Indicators:**
Percentage of renovated IHCs Percentage of HDs with senior staff trained in HD management Percentage of HDs and IHCs conducting monthly monitoring exercises Percentage of supervisory missions carried out per health district by IHC workers	% of IHCs offering immunization in their packages of activities % of IHCs offering comprehensive and high-quality essential packages of interventions	Rate of Penta 3 immunization coverage MCV vaccination coverage rate Penta 1 / Penta 3 drop-out rate

Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.

Key activities:	Intermediate Results:	Immunization outcomes:
Organize outreach and mobile strategies as well as campaigns offering essential packages of interventions, including immunization, to indigenous populations and those in areas that are difficult to access.	Improved and equitable access to immunization services Improved access to essential packages of interventions for indigenous populations	Immunization coverage is improved on an equal basis in each health zone
Provide 40 IHCs with solar and electric cold chain equipment		Increase in the number of fully vaccinated children
Implement communication plans for routine vaccination and the delivery of the high-impact package of services in the 7 health districts who perform poorly	Improved use of immunization services in the HDs	Immunization drop-out rates are reduced in the HDs
Related Key Activities Indicators	**Related Intermediate Results Indicators:**	**Related Immunization Results Indicators:**
% of mobile and outreach strategies carried out, per HD and per period	Percentage of the populations that are difficult to reach, covered by the offer of quality essential packages of interventions, including immunization	Rate of HDs with immunization coverage for DTP3>80%

Number of IHCs with cold chain equipment	Percentage of IHCs and health districts with an EVM score higher or equal to 80%	Difference in percentage points for Penta 3 coverage between lowest and highest wealth quintile
Rate of HDs implementing communication plans focused on the demand for essential packages of interventions, including immunization	Percentage of populations having a positive perception of immunization	% of children fully immunized Penta 1/ Penta 3 drop-out rate % of health districts with a Penta1 / Penta3 dropout rate < 10%
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.		
Key activities:	**Intermediate Results:**	**Immunization outcomes:**
1. Provide health districts with computer equipment and modems to process and submit NHIS data	Improved report timeliness, completeness and quality	Sufficient and exact immunization data
2. Train NHIS data managers on the use of standard tools, collection methods and techniques, as well as data processing and analysis	Produce quality data and periodic reports on NHIS	
3. Twice a year, organize self-assessments and data quality audits of data provided by the IHCs (DQS and DQA)		
4. Organize the immunization coverage survey for the 4th quarter of 2017	Measure immunization performance and HSS-GAVI's impact	Availability of immunization coverage survey data for better planning
5. Organize the internal and external evaluation of the HSS-GAVI program at mid-point and at the project's completion.	Measure performance and HSS-GAVI's impact at mid-point and at the project's completion	Availability of HSS-GAVI performance data
Related Key Activities Indicators:	**Related Intermediate Results Indicators:**	**Related Immunization Results Indicators:**
% of health districts with computer kits and modems to process and submit NHIS data	Percentage of health districts producing high-quality periodic reports	Percentage of children fully immunized
% of NHIS data managers in health districts and HDDs trained on collection methods and techniques, as well as data processing and analysis	NHIS report completeness rate	Rate of HDs with immunization coverage for DTP3>80%
Rate of bi-yearly reviews and audits conducted per health district.	NHIS report timeliness rate	MCV vaccination coverage rate
	Percentage of IHCs for which administrative data reported falls within the <5% gap range per DQS report results	Penta 1 / Penta 3 drop-out rate
Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.		

Key activities:	Intermediate Results:	Immunization outcomes:
Undertake negotiations with mobile telephone companies to use their networks and mobile phones to promote immunization	The application exists (electronic registry, scheduling, standard reminder message)	Immunization coverage is improved on an equal basis in each health zone Increased number of children who are fully immunized in the HDs Immunization drop-out rates are reduced in the HDs
Acquire the computerized equipment required to ensure the development and distribution of electronic schedules and other applications on the mobile phones of the parents of children registered for immunization.		
Train community health workers on the implementation of essential packages of interventions and on communication techniques and provide awareness-raising tools.	Community health workers make the populations in health zones aware of essential packages of interventions, including immunization	
Implement the application using mobile telephone technology (development of a registry, electronic scheduling, and message distribution on mobile phones)	Awareness-raising messages about essential packages of interventions and reminders sent to mothers of children of immunization age via mobile phone in the health districts.	
Related Key Activities Indicators:	**Related Intermediate Results Indicators:**	**Related Immunization Results Indicators:**
Percentage of health districts using the innovative mobile phone approach Percentage of IHCs using the innovative mobile phone approach	Percentage of mothers reminded by electronic messages	Rate of Penta 3 immunization coverage Drop-out rate Percentage of children who are fully immunized
Objective no. 5: From now until the project is complete, strengthen governance and program management.		
Key activities:	**Intermediate Results:**	**Immunization outcomes:**
1. Advocate for restructuring of EPI's approach to management, provide EPI with additional supplemental technical personnel and give it the same status and authority as a central directorate as well as appropriate funding;	Restructuring of the EPI management structure; additional technical personnel for the EPI	Increased and secured funding for immunization
2. Provide EPI management with appropriate management tools	Appropriate management tools being used by the EPI	Improved immunization coverage
3. Support operation of the ICC and NITAG	Regularly operating ICC and NITAG	
4. Set up [national] immunization technical advisory group (NITAG)		
Related Key Activities Indicators:	**Related Intermediate Results Indicators:**	**Related Immunization Results Indicators:**
Existence of reformed EPI management entity	Percentage of HDs using EPI management tools	Rate of Penta 3 immunization coverage
Existence of program management tools	Number of meetings held by the	

Existence of operational funds for steering entities		ICC Number of meetings held by the NITAG		Percentage of children who are fully immunized

IMPACT: ***Please provide an impact statement and indicator(s)***

- Morbidity and mortality linked to vaccine-preventable diseases are reduced by 50%
- The under-five mortality rate has decreased, from 68 to 52 per 1000 live births
- The maternal mortality rate has decreased, from 426 to 407 per 100,000 live births

ASSUMPTION:

1. Conditions for success

The four main conditions for the success of this project are:

- ✓ High-level political commitment, specifically with support for the operational and peripheral levels. This commitment is the main guarantee of (i) robust leadership, (ii) sufficient mobilization of required resources and (iii) regulation and efficient control at all levels;
- ✓ Commitment from various partners so that there is true support provided for this strategy:
  The HSDP project calls strongly upon the World Bank for health system strengthening in Congo. Project synergy is important. Synergy is crucial and support from other partners such as GFATM, UN partners--specifically UNFPA, along with other partners, including the private sector;
- ✓ Mobilization, preparation and training of civil society and communities so that they are actively involved in the implementation of this project: Involving civil society and communities guarantees a certain "citizen control" over the implementation of this project all while ensuring its orientation toward the real needs of the population;
- ✓ Involving local, decentralized entities, including indigenous communities, in the operational planning and implementation of activities targeting equitable access to the essential packages of interventions.

2. Measures and reforms required

For the implementation of this project, various measures and reforms are necessary to correct inadequacies and the other weaknesses that characterize the health system. These are:

- ✓ the creation of policy documents (new NHDP, new cMYP, etc.), and a certain number of reference documents, such as the health map, the national strategy for community approaches, the strategy for improving the quality of health care and services; the texts reinforcing the effective decentralization of health services and the strategic plan for developing human resources, so as to better guarantee universal access to quality essential packages of interventions; accelerated implementation of the HR development strategy as well as reform of human resources in the health sector, the nomination of senior staff and personnel at all levels;
- ✓ decentralized management of services based on performance and the use of performance contracts;
- ✓ development and strengthening of the national quality assurance system at all levels;
- ✓ implementation of a plan for transferring responsibility negotiated with GAVI and all partners involved in implementation, to secure sufficient budget line items for the purchase of vaccines and the operation of the EPI.

FOUR PAGES MAXIMUM

14. Monitoring and Evaluation

Mechanisms and activities for the monitoring and evaluation plan

The situational analysis of Congo's 2011-2015 national monitoring and evaluation plan revealed the main challenges that the country is facing in this regard. They are: (i) the weaknesses of the National Health Information System (NHIS); (ii) the lack of functioning of monitoring and evaluation entities; (iii) the lack of formal mechanisms and the lack of a culture of evaluation; (iv) the weak capacity to produce data in supplement to routine data provided by NHIS and (v) the lack of funding dedicated to monitoring and evaluation.
The 2015-2016 PBDS[34] strategic orientations related to NHIS strengthening as well as the recommendations on monitoring and evaluation provide appropriate responses to these challenges. Therefore, the monitoring and evaluation mechanisms for the HSS-GAVI grant will be used in addition to the PBDS monitoring and evaluation mechanisms.

At the national level
Inter-agency coordinating committee supporting the EPI immunization program.

At the departmental level
- Departmental councils;
- Health department directorates;
- Health districts.

Monitoring will be periodic (quarterly, twice-yearly or annually) and will occur at all three levels of the health care system. It will include: (i) administrative data generated by the health centers and hospitals in the context of the routine NHIS; (ii) the results of the various studies and surveys: 2015 MICS survey, 2016 immunization coverage survey, EDSC-III in 2017 and (iii) various other health sector studies such as the review of public expenditures, national health accounts as well as internal and external evaluations of health sector projects.

Monitoring will be the joint responsibility of the following institutions:
- Directorate General of Hospitals and Healthcare Organizations;
- Directorate General of Epidemiology and Disease Prevention;
- Directorate General of Population;
- Directorate for Planning and Research.

With the technical and financial support of the partners, a technical team made up of senior EPI staff and staff from the facilities previously mentioned will be in charge of processing, analyzing and summarizing sector data from various sources. Data gathered from monitoring will show to what degree expected results have been attained and will allow for appropriate corrective measures to be taken. The results summarized from all of these data sources will be used to populate the dashboard used to monitor the PBDS implementation.

This proposal's monitoring and evaluation, then, includes, in addition to strengthening the national health information system, supportive supervision, monitoring exercises focused on equity in access and use of health services, organization of DQAs & DQSs as well as quarterly and annual reviews. The monitoring meetings will be institutionalized in all health districts and health zones. An external evaluation is planned for project completion. The budget proposed for monitoring and evaluation integrates all these different aspects.

Supportive supervision is a key mechanism for strengthening the capacities of health facility personnel. The activities will be executed by the health centers under the supervision of the senior teams. Quarterly supervisory activities by the departmental level of the health districts are planned, as are monthly supervisory activities conducted by the health districts of the health centers as well as by supervision by the

[34] *2015-2016 Biennial Health Services Development Plan. MPH, 2014. See Pages 90 - 96*

health centers of the community health workers.
The technical and financial partners for the health sector, representatives from related sectors (Budget, Planning, Finance, Education, Gender) and civil society organizations will participate in activity report validation meetings at all levels of the health care system. At the central level, data will be validated by the ICC, distributed and submitted to the various parties participating in the project.

The main intermediate results as well as results specific to immunization will be at the core of the process and the various monitoring and evaluation activities detailed in this proposal. The various indicators that will be evaluated are discussed below in relation to the targeted outcome.

Outcome no. 1: Quality essential packages of interventions including immunization be offered in at least 90% of the target health districts.
Percentage of IHCs fulfilling the conditions for functionality;
Percentage of IHCs offering complete and high-quality essential packages of interventions;
Percentage population covered by essential packages of interventions, per strategy (fixed, outreach and mobile).

Outcome no. 2: The percentage of children who are fully immunized in all health districts including groups within marginalized populations be increased to at least 90%.
Percentage of health districts implementing the five components of RED;
Percentage of IHCs with a functioning cold chain;
Percentage of IHCs and health districts with an EVM score higher or equal to 80%;
Percentage of cases of those refusing immunization.

Outcome no. 3: 100% of departmental directorates and the senior management teams of the 30 health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.
Percentage of health districts producing high-quality periodic reports in the recommended format;
NHIS report completeness rate;
NHIS report timeliness rate;
The administrative data reported by the IHCs are in the <5% gap range per DQS report results.

Outcome no. 4: Increase the demand for essential packages of intervention offerings, including immunization, in the targeted health districts, using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.
Availability of electronic schedule and reminder messages;
Percentage of health districts who have begun implementing the innovative mobile phone approach

Outcome no. 5: Governance and program management are to be strengthened
Existence of reformed EPI management entity;
Existence of program management tools;
Number of meetings held by the NHDP steering committee;
Number of meetings held by the ICC.
The data provided by the 2013 JRF show that the gap between the administrative data and the data gathered from surveys is quite significant. While the WHO-UNICEF estimates show that 69% of children have been vaccinated with DTP3 in 2013, the administrative data show coverage of 85%, a 16-point difference. This situation explains the fact that this proposal devotes US$ 1,179,895, close to 23% of the total application budget, to funding activities targeted at improving data quality, included in the monitoring and evaluation plan. Outside GAVI, the other health system strengthening programs like HSDP II and the joint project will fund the various monitoring and evaluation aspects noted in the NHDP.

TWO PAGES MAXIMUM

PART E – BUDGET, GAP ANALYSIS AND WORKPLAN

15. Detailed Budget and Workplan Narrative

Table no. 7 shows a budget summary for the 3 years of proposal implementation per objective. It shows that the GAVI's crucial support is targeted for activities that will be developed in the health districts, health centers, and, especially for the development of community strategies.

The detailed procurement plan (in the appendix) shows that it would be necessary to invest **$US 1,193,645.23** for the first 18 months. For certain purchases, the initial unit costs were in FCFA. For these, a rate of exchange of 500 FCFA to 1 USD has been applied.

Table 7: Summary of budget for the proposal per objective

Objectives of the HSS proposal	Item cost per period			Totals	%
	2015	2016	2017	2015-2017	
Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.	556,804.50	612,196.50	167,979.20	1,336,980.20	30%
Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.	938,668.90	343,337.60	93,850.30	1,375,856.80	31%
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.	89,301.60	20,000.00	39,800.00	149,101.60	3%
Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.	295,510.80	218,748.00	108,348.00	622,606.80	14%
Objective no. 5: From now until the project is complete, strengthen governance and program management.	459,712.20	365,711.00	110,021.30	935,444.50	21%
GRAND TOTAL	2,339,998.00	1,559,993.10	519,998.80	4,419,990	100%

Objective no. 5 is about strengthening governance and program management. In addition to the funds related to EPI strengthening and coordination entities, there are budgets planned to cover the "management fees" of the two main execution partners, WHO and UNICEF. The amount of these fees is US$ 917,768.1 which is 20.76% of the global budget.

The management fees include two items:

1. The funds for technical support which represent 15.76%. They will be used to pay part of the salaries for the staff that will be used to implement the project, to purchase and maintain vehicles and computer equipment, to conduct supervisory missions in the field, and to ensure participation at various project meetings.
2. The funds for indirect costs which represent 5%. These funds will be used at the headquarters of

these two agencies for overhead

The unit costs included in the detailed workplan and budget reflect what is really applied in Congo by UNICEF, WHO, GFATM and EPI.

Five types of expenditures can be distinguished:

1. Supplies will principally be procured through UNICEF. Unit costs come from the UNICEF Supply Division (Copenhagen) catalog and are reproduced in the appendix called "Procurement Items from Supply Division."
2. Training, workshops, monitoring and supervisory meetings as well as the costs of voice calls and the recommended SMS messages for the mobile phone application are calculated in detail in the appendix called "Breakdown Budget GAVI Proposal Excel sheet." The costs are those applied by GFATM and EPI in Congo. They are in FCFA, then converted in USD and the average is defined according to the unit used for of a specific expenditure (HD, IHC, etc.).
3. Renovations led by WHO are based on the estimate made by WHO when the joint project was being developed and are an accurate reflection of the reality in Congo.
4. The cost of the campaign for essential packages of interventions including immunization for indigenous populations and those who live on rivers is based on UNICEF's experience with similar activities conducted in the country. These costs do not include those related to the procurement of medicines or vaccines. These costs are made up of contributions from the government and UNICEF for health system strengthening in a global manner.
5. The other costs such as those for the procurement of management tools for EPI and health districts are the same costs applied by the EPI.

The CSOs will take part in the project's implementation. No funds will be allocated directly to them because they are not key implementing entities and their funds will go through UNICEF. In total, the CSOs will receive US$ 622,476 for the implementation of their local activities, as explained in section 19 of this document which addresses CSO participation.

TWO PAGES MAXIMUM

16. Gap Analysis and Complementarity

In June 2014, the government of Congo signed the agreement with the World Bank for the implementation of the HSDP-II project as a cofunded project (US$ 100 million from the government and US$ 20 million from the World Bank). The HSDP-II focuses on introducing a new system of paying service providers and of funding facilities, based on performance, to contribute to revitalizing the health districts.

The government of Congo is in negotiations with three UN (WHO, UNICEF and UNFPA) for the financing of a joint project to accelerate the reduction in maternal, neonatal and under-give mortality, through revitalization of the health districts. The goal of this negotiation will be a source of funding for health system strengthening, in complement to GAVI's support.

Table 8: Distribution of HSDP-II and HSS-GAVI Project Financing per objective

Objectives	Total required	HSDP II	GAVI Contribution	Gap (to be financed by the GoC)
Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.	111,703,333	101,192,333	1,333,480	9,177,520
Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.	2,821,078	945.343	1,368,504	507.231
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.	1,838,235	875.000	160.749	802.486
Objective no. 4: From now until the project is complete, increase the demand for essential package of service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.	4,642,000	1,585,200	622,607	2,434,193
Objective no. 5: From now until the project is complete, strengthen governance and program management.	2,010,948	578,186	934,650	498,112
Total	**123,015,595**	**105,176,063**	**4,419,990**	**13,419,542**

Outside the investment budget for construction and health facility equipment (hospitals and health centers), the PBDS has planned for an amount of **US$ 123,015,595** in 2015-2016 to begin the complete revitalization of the HDs in Congo. The HSDP contribution is estimated at **US$ 105,176,063** The HSS-GAVI is estimated project at **US$ 4,419,990** There is a gap of **US$ 13,419,542**. This gap will be filled by additional government support and support from the government's various technical and financial health partners.

The HSDP-II addresses various aspects of the health system, but there are still other areas that need work and geographic areas which are not targeted by these interventions. The HSDP-II intervenes in 7 out of the country's 12 departments: Bouenza, Brazzaville, Pointe-Noire, Niari, Plateaux, Pool and Cuvette.
As for the HSS-GAVI project, it covers 7 health districts within the Bouenza, Brazzaville, Pool, Cuvette and Likouala departments. The two projects are supporting 6 health districts at the same time, for which, if an improved offer of essential packages of interventions is achieved due to HSS-GAVI support, this will facilitate the continuation of performance based funding in the context of HSDP-II. Table no. 9 gives a breakdown of activities that shows the complementarity between HSDP-II and the HSS-GAVI project.

Table no. 9 Breakdown of activities between HSDP-II and the GAVI Project, Congo, August 2014

Activity	Partners		Comments
	HSDP II	GAVI Project	
1.1- Renovate/repair the buildings of the 20 operating health centers as needed			For PBF in the HDs, the IHCs will plan for their minor repair needs and they will perform them, themselves, using PBF funds
1.2- Draft integrated micro-plans using bottleneck analysis results from the 84 health zones			The point of departure for improving performance is to create a good plan of action that is adapted to local realities to correct inequities in the use of services.
1.3- Draft integrated micro-plans using bottleneck analysis results from the 7 health districts			During this process, each health district will have an integrated operational plan for which the activities will target improving immunization coverage and PBF indicators.
1.4- Provide 40 IHCs with equipment and technical materials			For PBF in the HDs, the IHCs will plan for their needs, and for minor supplies and equipment, they will procure them, themselves, using PBF funds
1.5- In 84 IHCs, implement management tools for activities including instructions and guidelines for using them.			This activity will be undertaken jointly because the HSDP buys the indicators linked to home visits but the GAVI project develops an important communication home visit component
1.6- Organize 7 training sessions (1 per HD) for HD senior staff members and IHC nurses on the implementation of the essential package of interventions, community activities, conducting supervisory and monitoring meetings			The training manual will be finalized in cooperation with the experts for these two projects so that the same document will be used everywhere
1.7- Develop and distribute the manual for worker supervision and activity monitoring coverage in the health districts, and distribute it.			The supervisory manual will be drafted in cooperation with the teams for these two projects so that the same document will be used everywhere
1.8- Organize the monitoring sessions for essential packages of service coverage, specifically immunization coverage for all health zones (organization of community assemblies)			This activity will be conducted jointly between the two projects. The HSDP will purchase the indicator linked to monitoring and the GAVI project will verify the content and the quality of this monitoring
1.9- Organize the monitoring sessions for essential packages of service coverage, specifically immunization coverage for all health districts			This activity will be conducted jointly between the two projects. The HSDP will purchase the indicator linked to monitoring and the GAVI project will verify the content and the quality of this monitoring
1.10- Organize monthly supervisory missions by the HDs of the IHCs			The GAVI project will be responsible for conducting training of supervisors, with modules that have been jointly finalized
1.11- Organize quarterly supervisory missions by the HDDs of the HDs			The supervisory tool will be jointly finalized by the two 2 projects and applicable throughout the entire country
1.12- Organize monthly supervisions of community health workers by the IHCs			The GAVI project will be responsible for conducting training of supervisors, with modules that have been jointly finalized
1.13- Organize twice-yearly supervisory missions by the EPI central office of the HDDs.			The community health workers who have been trained should be provided with the support necessary to do their work, in cooperation and harmony with the HSDP
4.2- Identify and train at least 840 community health workers on locating drop-outs and on when they are not located, the implementation of the essential packages of services and immunization activities, message delivery, home visits and the promotion of health			This activity will be undertaken jointly because the HSDP buys the indicators linked to home visits but the GAVI project develops an important communication home visit component
4.3- Provide community health workers with			This activity will be undertaken jointly because the

the tools to raise awareness and the visibility required to conduct their activities			HSDP buys the indicators linked to home visits but the GAVI project develops an important communication home visit component
4.4- Train members of the 84 health committees on the role, operations and management of community health care			The training manual will be finalized in cooperation with the experts for these two projects so that the same document will be used everywhere
4.5- Organize mass awareness-raising sessions			The GAVI project will be responsible for this activity but in cooperation with HSDP-II
4.6- Organize home visits in the health zones targeted for intervention			This activity will be conducted jointly (HSDP is going to buy the indicators for home visits)
4.7- Ensure that the counting of households in the health zones is organized by community health workers			The GAVI project is going to conduct this activity; it will provide major support to HSDP-II in identifying and counting the indigenous population.
1.12- Organize monthly supervisions of community health workers by the IHCs			This activity will be undertaken jointly because the HSDP buys the indicators linked to home visits but the GAVI project develops an important communication home visit component
2.1- Provide 5 HDs with 15 HP outboard motor boats for supervisory activities and mobile strategy			Providing the IHCs with necessary equipment is crucial for the success of outreach and mobile strategies and the supervision of community health workers. Similar acquisitions are planned by the HSDP
2.2- Provide 84 IHCs with motorbikes for supervisory activities and mobile and outreach strategies			These motorbikes will be provided for the entire country by HSDP-II
2.3- Provide the EPI central office and 7 HDs with vehicles for supervisory activities and mobile strategy			These motorbikes will be provided for the entire country by HSDP-II
2.5- Provide the support required to organize outreach and mobile strategies in health districts, particularly for accessing indigenous peoples			Mobile strategies will be organized more carefully to reach populations in areas that are difficult to access, particularly indigenous peoples: these activities are specific to HSS-GAVI
2.6- Organize campaigns offering essential packages of services, including immunization for indigenous peoples and those who live on rivers.			This approach was developed in Congo by UNICEF to bring as many high-impact essential packages of interventions as possible to the populations that live on rivers and are difficult to access via land routes.
2.7- Organize training sessions on EPI management, planning, program M&E, vaccine management, cold chain equipment management, and EPI data management for those involved in the EPI at the central level and in the HDDs			The training manual will be finalized in cooperation with the experts for these two projects so that the same document will be used everywhere
2.8- Train senior staff at 7 HDs and nurses at IHCs on MLM and EPI program management.			These training sessions will be organized in cooperation with HSDP-II and will allow for the strengthening of the technical skills of the participants involved
2.9- Provide 40 IHCs with solar and electric cold chain equipment			The project will provide the targeted health facilities with solar refrigerators
2.10- Regularly verify vaccine and other EPI input transport from the central level to the centers.			Strengthening the cold chain capacity with solar/electric sources of cold in 40 IHCs will allow quality vaccines to be administered even when the electricity fails
2.11- Train 2 workers per health district on the maintenance of cold chain equipment			This involves advocating for timely co-financing, and to finance the acquisition of routine vaccines as well as a sufficient number of campaigns.
2.12- Develop and implement communication plans for routine vaccination and the delivery of the high-impact package of services in the 7 health districts who perform poorly			The GAVI project will be responsible for this activity but in cooperation with HSDP-II
2.13- Conduct advocacy for a budgetary allocation designated for the maintenance of cold chain materials, motorbikes and			Adapted communication plans will be developed while keeping these specific issues in mind

vehicles			
3.1- Provide 7 health districts with computer kits and modems to process and submit NHIS data			The HSDP has an innovative approach for this activity; it will be implemented in the intervention zones.
3.2- Provide electronic entry and processing support for NHIS data			Making it available to all will contribute a noticeable improvement in the quality of routine EPI data
3.3- Train those who work with NHIS at the 7 HDs on collection methods and techniques, as well as data processing and analysis			Materials for managing packages of services will be made available in all health facilities.
3.4- Twice a year, organize self-assessments and data quality audits of data provided by the IHCs (DQS and DQA)			The DQS and DQA have mechanisms to ensure the quality of the coverage data submitted. In the context of PBF, the HSDP is particularly interested in data quality.
3.5- Organize the immunization coverage survey for the 4th quarter of 2017			The immunization coverage surveys will allow for an objective analysis of if the program is leading to improved immunization indicators.
3.6- Organize the evaluation of the GAVI-HSS program at mid-point and upon its completion			The availability of appropriate tools will facilitate the implementation of performance based funding, particularly for immunization
4.8- Undertake negotiations with mobile telephone companies to use their networks and mobile phones to promote immunization			Meetings with the two main telecommunications companies will lead to finalizing an agreement for their participation in the project
4.9- Organize the official signing ceremony for the partner agreement with the mobile phone operators			This official ceremony needs to be a major awareness-raising event for decision-makers and the general public about the challenges and issues facing immunization in Congo.
4.10 Acquire the computerized equipment required to ensure the development and distribution of electronic schedules and other applications on the mobile phones of the parents of children registered for immunization Purchase the server and features.			This will take place through the acquisition of the server and personnel training
4.11- Ensure the implementation of the mobile phone application: Cost of automatic voice calls to families who have not immunized their children			The issue is to allow these individuals to have access to relevant health information transmitted to their telephones
5.1- Advocate for restructuring of EPI's approach to management, provide EPI with additional supplemental technical personnel and give it the same status and authority as a central directorate as well as appropriate funding			The expected restructuring and additional human resources should have an immediate impact on program management
5.2- Provide EPI management with appropriate management tools			This is mostly referring to electronic vaccine inventory management tools, cold chain equipment, as well as immunization databases and equipment.
5.3- Support the NHDP steering committee and the ICC			This support should lead to rejuvenating not only the NHDP and its technical committee, but also the ICC so that it meets more regularly and is more efficient.

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17. Viability

The viability of the results obtained by the government of Congo with HSS-GAVI support depends on political stability and security, macro-economic stability in addition to the successful implementation of recommended reform in the health care sector.

Due to its GDP, Congo is classified as an intermediate income country and is, therefore, a Graduating country and will no longer receive GAVI support after 2015.

Congo's performance and economic perspective remain positive overall but its structural transformation is still a major challenge. The real GDP growth rate decreased from 3.8% in 2012 to 3.4% in 2013, due to the decline in oil production along with aging oil wells. GDP growth should, however, reach 6.1% in 2014 and 6.5% in 2015. These macro-economic perspectives are supported by a State investment program, the beginning of mining production, and the vitality of non-oil sector.

Inflation, estimated at 2.9% in 2013, should remain under the regional convergence threshold of 3% for 2015 due to prudent monetary and budgetary policy. The fiscal and external current account balances positive for 2013, respectively at 12.1% and 4.9%, and should continue to improve in 2014-2015. But, the diversification and transformation of the Congolese economy and the significant increase of the impact of growth on social indicators remain a major challenge for the country. In essence, the growth of the Congolese economy remains insufficient and not inclusive enough to significantly reduce poverty. Even though it decreased from 50.7% in 2005 to 46.5% in 2011, poverty remains a significant issue for an intermediate income country, as does unemployment, especially for youth in the 15 to 29 age bracket, where the unemployment rate is 25%. Accelerated reform programs, specifically in areas of the environment, private investment, the development of competencies and infrastructures and public financial management, are crucial if these challenges are to be resolved.

To remove these obstacles, the government, through its 2012-16 National Development Plan (NDP), is focusing on: i) increasing investment in infrastructure and developing competencies; ii) improving the business climate; iii) improving SME access to funding; iv) creating Special Economic Zones (ZES in French); and v) strengthening regional integration.
Current efforts to strengthen decentralization in the country as well as the reforms envisaged for the health sector will enable the facilities' institutional capacities to be strengthened, with better funding and maximum functionality for health districts.

The project's technical viability will be guaranteed by activities that strengthen capacity, strengthen the logistics chain and the transfer of the knowledge learned throughout the project. All levels of the health care system will benefit from this training. Representatives from local civil society and communities will also be selected for this training to become community health workers.

Strengthening the cold chain with solar equipment will enable various health facilities in Congo to become independent of the electrical system; electricity is not always available at any given time or throughout the entire country. Furthermore, providing the health districts with vehicles, outboard motor boats, motorbikes and bicycles will enable this experience to be used to make outreach strategies and supportive supervision sustainable.
With the government's own funds, a general hospital is currently being built in the seat of each department. In addition, more than 1,000 young Congolese are being trained in Cuba and in various other countries in medical and pharmaceutical studies. This investment will significantly increase the health services offered in Congo, including immunization.

The issuing of order no. 2013-280 dated 25 June 2013 about the creation of the community health management committee (see document in the appendix) offers a major opportunity to involve and work with communities within an organized and structured context. The community health workers also will work within the framework of the Community Health Management Committee (CGDC in French) so that their actions have a much greater influence.

The project's financial viability will be reasonably assured, due to its limited cost and the opportunity for significant funding targeted at health system strengthening provided by the government through two major projects: HSDP-II (close to US$ 120 million) and the joint WHO-UNICEF-UNFPA project (close to US$ 35 million).

The project will contribute to increasing the efficiency of health expenditures where the results of current total health expenditures of 37 dollars per inhabitant will be improved due to the implementation of the performance-based funding project, to the adoption of waiving payment for the poor and also to the implementation of a program linked to social protection, run by the World Bank (LISUNGI Project). In essence, the LISUNGI project proposes a conditional system of transfers in cash to improve the health of a targeted group of the poor and the elderly in the Republic of Congo.

As part of the Medium-Term Expenditure framework for health (MTEF-health), increased expenditures are anticipated in the social sectors, particularly in the area of health, in accordance with the poverty-reduction strategy. Thus, the Ministry of immunization is going to activate two strategic approaches.

The first is related to the strategy of improving the efficacy of available resources. The goal is to attain better results through rational and efficient resource management which will be made possible, among others, for the reduction of the vaccine wastage rate, improving coordination at all levels, conducting regular quality control, and training/retraining of managers.

The strategy of improving the sustainability of resources that can be mobilized is the second of these two approaches. With respect to this aspect, it is important to be sure that the funds that are included in the budget be entirely disbursed within a reasonable period of time to complete the planned tasks. An activity program plan and a monthly treasury plan need to be established to comply with the rules and the rate of budget execution at the national level.

TWO PAGES MAXIMUM

PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

18. Implementation Arrangements

a. Main management entities

The main management entities are:

At the central level, the Inter-Agency Coordinating Committee is the main entity used for coordination and grant implementation. Technical documents for the implementation of essential packages of interventions will be approved by the ICC as will the operational plans and implementation reports. At the decentralized level, the departmental directorates will be responsible for monitoring service implementation. The departmental councils and their committees will assist with overall coordination and the mobilization of resources at the local level.

b. Application implementation partners

The application implementation partners UNICEF and WHO are both involved in the technical and financial management of the project. WHO and UNICEF will work with the Ministry of Health and Population's entities and services at all levels, and with partners and NGOs, to guarantee the required synergies as well as results. The choice of these two partners for the implementation of this application results from an in-depth analysis that was conducted by the MPH and various partners. Their goal was to gain maximum benefit from the opportunity being offered by GAVI's support for an efficient health system strengthening. This decision was based on the following:

- The MPH was the main recipient of the GFATM grants for round 8 (Malaria and Tuberculosis) as well as rounds 5 and 9 (HIV). The implementation of these projects was not a success: the targeted outcomes were not reached; financial management of these projects showed almost US$ 3.7 million of ineligible expenses for which the government had to reimburse GFATM. The government is aware of the strong links between GFATM and GAVI funding, and learning from these past experiences, the government decided to have WHO and UNICEF execute the HSS-GAVI grant.
- The government recognizes WHO and UNICEF's technical expertise with regard to health system strengthening and immunization.

c. Mechanisms for receiving and managing HSS-GAVI resources

Based on the points mentioned in point B, the management mechanism recommended can be summarized as follows: (i) GAVI sends the funds to the government, which receives them in an account opened for this purpose by the Research and Planning Department (DEP); (ii) the DEP, after getting approval from the ICC, disburses the funds to both WHO and UNICEF as detailed in the budget submitted to GAVI; (iii) WHO and UNICEF execute the project in compliance with the rules of administrative and financial management then give an accounting of the results obtained financial management and (iv) the technical and financial reports prepared by WHO and UNICEF are submitted to the ICC.
A joint memorandum of understanding was signed by the Ministry of Health and Population and the WHO and UNICEF representatives in Congo to enable modalities to be decided upon for the implementation of the project and each party's obligations.

d. Application implementation mechanisms

Annual planning.
Each health district and all other facilities involved in this funding will develop an integrated action plan (IAP) for HSS. This plan will specify the activities before being funded by RSS-GAVI. These IAPs will be consolidated at the intermediary level and then at the central level. The IAP activities consolidated at these

two levels will receive GAVI funding and will be merged into a budgeted annual workplan (referred to as PTBA in French). In collaboration with the Ministry of Health's technical services group, WHO and UNICEF will develop disbursement plans, based on the PTBAs. The budgeted annual workplan and disbursement plans will be presented for ICC approval.

Funding accounts
The annual disbursement plans submitted to GAVI will be reviewed and approved regarding the disbursement of funds to the DEP, annually, so that the activities included in the PTBAs can be implemented. The funds transferred to the DEP will be transferred annually to the accounts of the two implementation partners, as per their areas of competence as detailed in the application document, the PTBA and the memorandum of understanding.

Funds management.
Funds management will mainly be the responsibility of WHO and UNICEF, in compliance with the respective procedure rules. These two partners are responsible for the management of funds targeted at both investments (purchase of material and equipment, etc.) and operational activities.

Implementation of activities.
For the implementation of activities, each health district will draft a quarterly work plan that refers back to the PTBA. The quarterly work plan must be approved by the departmental directorate. Funds will be made available to the health districts and other beneficiaries in the following manner: (i) Each implementation structure will draft a funds request that will be addressed, through the system hierarchy, to WHO or UNICEF, as appropriate; (ii) the application letter for the request to WHO or UNICEF will be signed by the Director of the ministerial cabinet in charge of health (iii) after the request has been reviewed and approved, the funds targeted for activities will be transferred to the beneficiaries' bank accounts.

Operational monitoring of activities.
This monitoring is the responsibility of the entities in charge of execution; they receive support and assistance from WHO and UNICEF. At the health district level, senior staff will conduct the monitoring during supportive supervision of IHC workers, when the monthly activities review meetings take place, during exercises to monitor coverage and DQAs. The same process will be used for the health departments. The health departments monitor the health district activities.

At the central level, the DEP and the relevant general directorates and the EPI will monitor the implementation of their own activities as well as monthly monitoring of the departments. The CHMCs and other civil society organizations will monitor community-level activities. A quarterly, twice-yearly and annual technical project activity implementation report will be drafted by the implementing facilities; these reports will be submitted to the two execution partners (WHO and UNICEF).

Strategic monitoring and evaluation.
The DEP is responsible for this type of monitoring. This monitoring will combine operational monitoring with research into the health system, studies and other analysis.

Resources allocated to program management.
The program will be managed by the two execution partners. The management fees represent 20.76% of the global budget, $917,768.1, which includes 5% of overhead for the two UN agencies, and 15.76% for technical support (the salaries of the staff dedicated to the project, the purchase of vehicles and computers, supervisory missions in the field and participation at various project meetings).

Technical assistance.
International and national technical assistance is explained in detail in section 20 of this proposal.

TWO PAGES MAXIMUM

19. Involvement of CSOs

Experience in Congo shows that the CSOs are key partners in the successful implementation of the immunization program vaccination and/or health system strengthening.

At the central level: The CSOs participate at all meetings of the various coordination committees that are involved with HSS, immunization and other health issues. Therefore, the CSOs actively participated in drafting and validating this proposal.

At the **departmental level**: the CSOs provide technical support for the implementation of various health projects. They are key participants in the planning process and the monitoring of the activities being carried out.

At the operational level (HD and health centers), the CSOs are truly field agents. The CSOs have several facilities that provide health care, normally primary contact services. The CSOs participate in facility management meetings for both HDs and health centers. They also provide technical and logistical support for the implementation of activities out in the field. The encourage the population to use health services in general, and, immunization in particular, through their various institutions such as churches and through community health workers. It is for all of these reasons that the service providers' contracts contain specific indicators and are signed to further improve access to vaccination services in the selected HDs.

The CSOs took an active role in preparing this application. For its implementation, they will work as sub-contractors for the project's two main execution partners.

Specifically, for this application, the CSOs were involved in:

1. Identifying and training community health workers (objective 3)
2. Organizing community-level counting (objective 3)
3. Implementing mass awareness-raising activities in the mass media (objective 3)
4. Organizing home visits in the health zones selected for intervention (objective 3)
5. Implementing HD communication plans for health issues and for immunization (objective 3)
6. Organizing campaigns to access indigenous populations and those who live on rivers to provide them with high-impact packages of services (objective 2)
7. Generating indicators for the HSDP project that are related to performance-based funding. (objective 3)

Therefore, CSO participation will be effective through

i. their involvement in the HSDP II project II that focuses on RBF at the health zone and hospital levels

In Congo, there is an HSDP II project that is a joint initiative of the Congolese government and the World Bank. This initiative has a 5-year budget of US$ 120 million, US$ 100 million of which is from the government and US$ 20 million of which is from the World Bank. This project devotes close to 30% of its resources to developing community outreach. This represents a key bottleneck to attaining significant coverages. Congo's health system is based on UHCs and hospitals and they consume more than 70% of the health care budget. Few resources exist for health center operations and even less for the implementation of community outreach by CSOs and community health workers.

With the contracts that will be signed between the CSOs and HSDP II, the CSOs will contribute not only to generating the indicators to be purchased in the RBF, but also to conducting community satisfaction surveys for services offered. The CSOs will benefit, then, from the funding required to carry out this work.

In Congo, there are not many CSOs and even fewer at the peripheral level. With this HSDP II initiative, we hope that there will be energy at the community level and that functioning CSOs can successfully operate and support the work that is taking place at the health facilities. This system of financing has the advantage of improving health facility performance, and, additionally, the various indicators for this HSS strengthening project.

ii. The signing of service contracts with NGOs focusing on marginalized populations and

populations that are difficult to access

In the Likouala department, UNICEF is funding the NGO ASPC. This organization conducts activities related to delivering high-impact packages of services for populations that live along the river. Once a quarter or twice per year, this NGO uses specially setup embarkations to provide essential packages of services to those who live on rivers, according to the availability of funds and inputs. This same approach will be followed with the HSS-GAVI project. Contracts will be signed with ASPC and other CSOs to deliver vital health services to populations that are difficult to access.

iii. CSO support for social mobilization at the community level:

The CSOs are involved in implementing HD communication plans for health issues and for immunization. To this end, traditional leaders, elected officials, religious leaders local figures, the CHMCs, NGO representatives and traditional therapists will contribute to the information used and to social mobilization via churches and mosques, ceremonies, local radio and town criers. The CSOs will also help with the implementation of electronic scheduling and messages to remind the mothers of children who have been registered for immunization services.

iv. Advocacy for the mobilization of financial resources transferred to the local communities for the CHMC account for health care and immunization activities

The order related to the creation of the CHMCs gives the latter a certain number of responsibilities related to improving the population's social conditions. This order also provides the CHMC with a budget from the State that passes through local community entities.
Furthermore, the CSOs will be a valuable instrument for advocacy to ensure that these funds are disbursed so that CHMC activities can be carried out.

In total, for all HSS-GAVI activities in which CSOs are involved, a total amount of US$ 622,476 has been planned, as is noted in table 10 below. This funding will pass through UNICEF. For this project, UNICEF Is responsible for the community activities. In addition to funds, the CSOs will also benefit from funds from the Congolese government, the World Bank and various partners involved in the support of community activities.

Table no. 10: funds provided to CSOs to fund the activities planned for this project

ACTIVITY	TOTAL
Identify and train at least 840 community health workers on locating drop-outs and on when they are not located, the implementation of the essential packages of services and immunization activities, message delivery, home visits and the promotion of health.	46,152
Organize mass awareness-raising sessions in the mass media	217,800
Organize home visits in the health zones selected for intervention	113,400
Ensure that the counting of households in the health zones is organized by community health workers	59,340
Organize campaigns offering essential packages of services, including immunization for indigenous peoples and those who live on rivers	105,000
Provide community health workers with the tools to raise awareness and the visibility required to conduct their activities	80,784
TOTAL FOR CSOs	622,476

TWO PAGES MAXIMUM

20. Technical assistance

Two essential mechanisms will enable the strengthening of institutional capacities thanks to this technical assistance. These are mainly: (i) the production of tools and reference documents and (ii) the transfer of competence to local participants. In the context of this proposal, this mainly concerns conducting surveys, supply management and improving data quality, through periodic consultation.

A. International technical assistance

1. International technical assistance is required for the implementation of the new procurement medicine distribution center that is replacing the COMEG (Procurement Center for Essential and Generic Drugs). The availability of quality medicines is a prerequisite for increasing the use of health services and for developing the populations' trust in their health facilities. This trust will lead to an increase in the use of the immunization services that are offered by these same facilities.

2. Congo currently benefits from international technical assistance for issues linked to human resources in the health sector. With the support of the French Development Agency (AFD) and the European Union, a program is being developed to re-adapt curricula, initial and continuing training, hiring policy, and health personnel retention in the areas where personnel have been hired.

3. International assistance is required to conduct surveys like the MICS and EDS. These surveys will provide a factual basis for the immunization program's impact and its intra- and inter-sector contribution to the health system strengthening and the reduction of the maternal and under-five mortality rate.

4. International technical assistance is also required for efficient vaccine logistics and management. This assistance will be provided to the trained logisticians who are responsible for ensuring the maintenance of cold chain equipment and good vaccine management.

5. International technical assistance to support improved data quality and the data quality audits will also be required, for the challenges the country confronts in this domain: poor counting methods, significant gaps observed between administrative data and survey data.

6. International technical assistance on issues related to the transfer of responsibility after GAVI's support has ended and the EPI's financial viability will help with developing advocacy methods targeted at significantly increasing the budget allocations for immunization.

7. Finally, international technical assistance is required for the implementation of universal health coverage, to remove financial barriers to the access and use of health services, including immunization.

A. National technical assistance:

8. National technical assistance to implement monitoring of equity in the access and use of services as well as monitoring of bottlenecks to immunization services that have been identified at each, and to what degree they have been alleviated.

9. High-level national technical assistance to support the health districts with training on the use and maintenance of computer equipment as well as the use of NHIS tools. This should improve the collection, processing, analysis, and prompt submission of data to higher levels within the hierarchy.

10. National technical assistance for the installation and maintenance of solar cold chain equipment. This equipment has a high investment cost but is required in a country where electricity is not yet available everywhere. This technical assistance will be ensured through contracts signed with certain Congolese companies who specialize in solar equipment.

11. National technical assistance for training health personnel on PHC, for the MLM course and also assistance from the National Statistics Institute on conducting surveys, studies, macro-economic studies and other.

ONE PAGE MAXIMUM

21. Risks and Mitigation Measures

The country already carried out a risk analysis for the health sector when the HSDP II project was being confinanced by the Congolese government and the World Bank. This risk analysis can be found on pages 34-36 and 85-91 of the document entitled "*Project assessment document for an application for credit in the amount of SDR 6.6 million (equal to US$ 10 million) and in the amount of US$ 10 million USD for the HRITF in Republic of Congo for a health system development project.*

Description of risk	***Probability*** **(high, medium, low)**	***Impact*** **(high, medium, low)**	***Mitigation measures:***
Objective no. 1: From now until the project is finished, at least 80% of poorly performing health districts targeted offer comprehensive quality EPIs, including immunization, with an average usage rate of at least 50%.			
Institutional Risks - Changes in the Ministry of Health's team	Low	Low	ICC leadership for HSS-GAVI project management
Fiduciary Risks - Irrational use of funds and non-justifiable expenditures	Low	Low	- Financial execution by WHO and UNICEF - Regular quality assurance management and audits by the inspector general for health
Operational Risks - Weak capacity of senior HD staff	Average	Medium	- Training for the parties involved; - Supervision
Objective no. 2: From now until the project is complete, increase the percentage of children who are fully immunized from 75% to at least 85%, in all health districts, including groups of marginalized populations.			
Institutional Risks - Changes in the Ministry of Health's team	Low	Low	ICC leadership for HSS-GAVI project management
Fiduciary Risks - Irrational use of funds and non-justifiable expenditures	Low	Low	- Financial execution by WHO and UNICEF - Regular quality assurance management and audits by the inspector general for health
Operational Risks - Weak capacity of senior HD staff - Lack of participation by indigenous populations	Average	Medium	- Training for the parties involved; - Supervision - Strengthening community approach through involvement of local individuals from the indigenous populations
Objective no. 3: From now until the project is complete, lead at least 80% of departmental directorates and health districts to produce quality data and periodic reports, that adhere to the formats and timelines recommended by the NHIS.			
Institutional Risks - Poor coordination of interventions related to NHIS	Average	Medium	- Effective implementation of the NHIS strengthening strategy recommended in the 2015-2016 PBDS
Fiduciary Risks - Irrational use of funds and non-justifiable expenditures	Low	Low	- Financial execution by WHO and UNICEF - Regular quality assurance management and audits by the inspector general for health
Operational Risks - Still very limited use of computerized tools in the HDs - Dependence on mobile telephones	Low	Low	- Training for the parties involved; - Availability of communications equipment
Objective no. 4: From now until the project is complete, increase the demand for essential package of			

service offerings including immunization in the targeted health districts using community outreach and innovative approaches related to information and communications technology (ITC), via mobile phone technology.			
Institutional Risks - Changes in the Ministry of Health's team	Low	Low	ICC leadership for HSS-GAVI project management
Fiduciary Risks - Irrational use of funds and non-justifiable expenditures	Low	Low	- Financial execution by WHO and UNICEF - Regular quality assurance management and audits by the inspector general for health
Operational Risks - Still very limited use of computerized tools in the HDs - Dependence on mobile telephones	Low	Low	- Training for the parties involved; - Availability of communications equipment
Objective no. 5: From now until the project is complete, strengthen governance and program management.			
Institutional Risks - Changes in the Ministry of Health's team	Low	Low	ICC leadership for HSS-GAVI project management

22. Financial Management and Procurement Arrangements	
Question A: applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.	To define how GAVI funds are to be managed for HSS, Congo has reflected on 5 realities: 1. Its experience delegating funding for HSS programs during HSDP II is an innovative management mechanism that operates in compliance with World Bank procedures. This mechanism uses a technical cell to which the members are nominated in a transparent fashion using a competitive process. This process will be managed under the supervision of a steering committee made up of the Ministry of Health and Population and all health sector partners. This committee will evaluate the success of the process. 2. There is a risk for Congo, as a Graduating country, of a FMA (Financial Management Assessment) from GAVI. Experience shows that if a government or civil society organization must manage GAVI funds, the FMA will need to be conducted and the processes lasts a minimum of 12 months. Then, at the end of the FMA, Congo will no longer be able to benefit from GAVI funding since Congo will have already been removed from the list of countries supported by GAVI. 3. The difficulties in managing GFATM Grants (targeted at malaria and HIV) -- see the OIG audit report in the appendix -- show that management by state and civil society entities was a disaster. Consequently, the country is deprived of funding to prevent malaria, its leading cause of mortality. 4. The government recognizes the specialized technical expertise of UN agencies, and specifically that of WHO and UNICEF in the HSS and immunization fields. The support for governmental facilities has been a determining factor for maintaining continual improvement in the assessment indicators. 5. The transfer of funds directly from GAVI to the UN agencies involves an 8% management fee being paid to these agencies' headquarters. However, if the government were to transfer the funds to these UN agencies, the management fee would be 5% Based on these 5 issues, the Government of Congo recommends a management mechanism that can be summarized as follows: • GAVI sends the funds to the government who receives them into the DEP account; • The DEP, after approval from the ICC and/or the steering committee, disburses the funds to both WHO and UNICEF per their areas of expertise as

	outlined in the application and as detailed in the budget that was submitted to GAVI. • WHO and UNICEF are responsible for the project's execution and for being able to justify both the program outcomes and finances to the Ministry of Health and Population; • The Ministry of Health and Population presents the financial and program outcome reports during the ICC meeting for discussion and approval
Question B: Financial Management Arrangements Data Sheet	
Any recipient organization/country proposed to receive direct funding from GAVI must complete this Data Sheet (for example, MPH and/or CSO receiving direct funding).	
1. Name and contact information of focal point at the Finance Department of the recipient organization.	Mr. Marcelin Lebela, Director of Research and Planning Ministry of Health and Population Telephone: 00242066374666 / 00242055501191
2. Has the recipient organization already worked with GAVI, the World Bank, WHO, UNICEF, or the Global Fund for the prevention of AIDS, tuberculosis and malaria or other development partners and has it already received grants?	YES
3. If YES ▪ Please state the name of the grant, years and grant amount. ▪ For completed or closed grants of GAVI and other development partners: please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. ▪ For on-going grants of GAVI and other development partners: please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	The Ministry of Health and Population has already received funding from various organizations including GAVI. In the framework of this application, GAVI funds will pass through the DEP account which will then transfer them to the WHO and UNICEF accounts.
Oversight, planning and budgeting	
4. Which entity will be responsible for in-country oversight of the program? Please briefly describe membership, meeting frequency as well as decision making process.	The entity that will be responsible for program oversight at the national level is the ICC that was created to monitor the program's immunization component as well as, overall, all issues related to any funding from GAVI. The ICC is chaired by the Minister of Health and Population, and the UN agencies and other technical and financial partners

	(European Union, World Bank, bi-and multi-lateral entities) are members of the ICC as are the CSOs and MPH staff.
5. Who will be responsible for annual GAVI-HSS planning and budgeting?	The MPH's Department of Research and Planning will be responsible for planning, budgeting and creating annual progress reports (APR) related to the HSS-GAVI proposal. The DEP will work in collaboration with WHO and UNICEF, the Expanded Program on Immunization, Civil Society Organizations, and other partners and participants involved in implementation.
6. What is the planning & budgeting process and who has the responsibility to approve GAVI HSS annual work plan and budget?	A proposal implementation plan will be developed each year. The implementation plan will be approved and adopted by the ICC and/or the steering committee. The implementation plan will be drafted with the participating parties as described above in point 5. It will take into account the operational plans for each implementation facility to ensure complementarity between activities funded by the government and those funded by other partners. This plan, and an annual disbursement plan in the appendix, will be sent for approval to the GAVI Secretariat as part of the annual progress report. Once approved by GAVI, the funding will follow.
7. Will the GAVI-HSS program be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement (for example, SWAp, budget support or pooled funding)? Please provide the list of the authorized signatories for the release of funds and all requests for additional funds.	The funds will be transferred from GAVI to the DEP account (in FCFA) created for this purpose. In compliance with the memorandum of understanding that will be signed between the Ministry of Health and Population, WHO and UNICEF, the funds transferred to the HSS-GAVI account opened by DEP will be transferred to the accounts of the two UN agencies. The Director of Research and Planning will be the signatory for the HSS-GAVI account. The disbursement will take place upon authorization by the Minister of Health and Population after the ICC has approved the disbursement plan.
9. Will GAVI HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	The HSS-GAVI funds will be transferred to the HSS-GAVI account opened by DEP and then transferred to the local WHO and UNICEF bank accounts, respectively.
10. Would this bank account hold only GAVI funds or also funds from other sources (government	For the project implementation, an account exclusively dedicated to HSS-GAVI will be opened by DEP.

and/or donors - a “pooled account”)?	
11. Within the HSS program, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled.	YES The management entities for each HD facility will draft their work plan each quarter based on their IAP. Funds will be made available to the management entities in the following manner: • Each implementation structure (directorates, programs, departments and HDs) will draft a funds request. • The request for disbursement of funds will be addressed to WHO or UNICEF by the Director of Cabinet of the Ministry of Health and Population. • After the required analysis and corrections, the funds targeted to implementation facilities will be transferred to their respective bank accounts. • After execution of activities, the structure is to justify the total amount of funds received from the execution partner who has provided those funds • The execution partner can, at any time, request bank statements from the beneficiary facilities to compare with the information they have provided
Procurement	
12. What procurement system will be used for the GAVI-HSS Program? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners’ procurement procedures)	For significant investments like cold chain equipment, vehicles and other, the bid process will be carried out by the 2 implementation partners (UNICEF and WHO) who will apply the UN rules and system to this process.
13. Do you plan to procure certain items through GAVI's system in-country partners (UNICEF, WHO)?	YES
14. What is the staffing arrangement of the organization in procurement?	There will be WHO and UNICEF personnel as detailed in point 12 above
15. Are there procedures in place for the physical inspection and quality control of goods, works, or services delivered?	YES. These are the procedures that haven been put in place by WHO and UNICEF for orders, receiving and distribution of the various inputs.
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES Complaint mechanisms exist at all levels. For example, all partners or organizations involved in HSS-GAVI implementation can go through the ICC and/or the steering committee to complain about a specific issue and it will then be investigated by these entities.

17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES / NO Disagreements are resolved by the ICC and/or the steering committee.
Accounting and financial reporting (incl. fixed asset management)	
18. What personnel is in charge of accounting and financial reporting?	Those in charge of operations and National Officers working in finance for these two organizations will be the personnel in charge of accounting and the preparation of financial reports
19. What accounting system will be used for the GAVI-HSS Program? (Is there a specific accounting software or a manual accounting system?)	WHO and UNICEF use their respective internal software applications.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	WHO and UNICEF will produce financial reports on a quarterly basis and address them to the Director of Research and Planning. These reports will then be reviewed by the ICC before being submitted to the GAVI Alliance.
Internal control and internal audit	
21. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES Do WHO and UNICEF have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?
22. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to HSS-GAVI.	YES WHO and UNICEF are subject to regular internal audits by auditors from these various organizations, using an audit procedure approved by the UN.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES WHO and UNICEF have these mechanisms internally.
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?	UN audit reports about HSS-GAVI funds management will be shared with the Ministry of Health and Population.
25. Who is responsible for the implementation of audit recommendations?	The implementation of audit recommendations and the external audit of accounts is the responsibility of the two implementation partners concerned by these

	recommendations, at all levels. The ICC ensures monitoring of the implementation of these indicators.
THREE PAGES MAXIMUM	

Question C: Please indicate the main constraints present within the (health sector's) financial management system. Does the country plan to address these constraints/issues?

The question of constraints in the health sector's financial management system was addressed in full in section 22 of this document. These constraints led to the proposal that this application be implemented by WHO and UNICEF instead of the Ministry of Health and Population due to all the difficulties and problems discussed.

HALF PAGE MAXIMUM