



**GAVI ALLIANCE**

**EVALUATION OF GAVI SUPPORT TO CIVIL SOCIETY  
ORGANISATIONS**

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17 January 2012

**COUNTRY EVALUATION REPORT - DRC**

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## ACRONYMS AND ABBREVIATIONS

Acronym	Full description
ANC	Antenatal Care
ARCC	Association des Rotary Club du Congo
CNOS	Conseil National des ONG Oeuvrant dans la Santé
CRRDC	Croix Rouge de la RDC
CRS	Catholic Relief Services
CSO	Civil Society Organisation
DEP	Direction des Etudes et Planification (of MOH)
DRC	Democratic Republic of Congo
EPI	Expanded Programme for Immunisations
GAVI	Global Alliance for Vaccination and Immunisation
HSS	Health System Strengthening
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NGO	Non Governmental Organisation
ONG	Organisation non-Gouvernementale (NGO)
SANRU	Santé en Milieu Rural (Congolesse NGO)

## EXECUTIVE SUMMARY

Given its size and complexity, and a conflict-ridden history that has left its infrastructure in disrepair, the needs for strengthening all aspects of the health sector in the Democratic Republic of Congo (DRC) are prodigious and far-reaching. The government is almost completely dependent on foreign donors to meet these needs. For almost ten years, the GAVI Alliance has made a significant contribution to a key area of health services – ensuring that newborns and young children are vaccinated against the many diseases endemic in Central Africa.

GAVI has supported DRC through four windows of support. *New and underused Vaccine Support (NVS)* funds are being provided for the purchase of vaccines including pentavalent and pneumococcal. *Immunisation Services Support* provides funds to boost immunisation in low-performing districts, covering vehicles and transportation, personnel, training and cold chain equipment. Funding for *Health Systems Strengthening (HSS)* attempts to fill operational gaps in the national EPI system. Under a fourth, more recent window GAVI has sought to engage *Civil Society Organisations (CSO)* in promoting public sector vaccination services, especially since CSOs very often have strong links in hard-to-reach areas. **Type A** CSO funding was made available for a national mapping exercise to identify CSOs with strong community links that could benefit from capacity building support. **Type B** assistance was designated for a CSO consortium led by the Congolese NGO SANRU (Santé en Milieu Rural) to provide that support to selected CSOs in strengthening EPI outreach in targeted health zones.

The CSO initiative is well appreciated by the DRC government, which is anxious to enlist CSOs in strengthening access to health services at the community level. At the same time, an evaluation of the CSO support programme revealed several flaws in design and implementation:

- *Sequence of inputs.* Type B funding was approved and activities commenced before the Type A mapping exercise could take place.
- *Transmission of programme funds.* An impediment to smooth functioning within the CSO consortium has been the fact that funds for the CSO initiative are not transmitted directly from GAVI to the CSO consortium, but through the Ministry of Health system.
- *Synergy with HSS window.* Areas of complementarity between GAVI's support for HSS and its Type B CSO funding have not been maximised.
- *Numerous lengthy interruptions in programme continuity.* These were caused by delays in approvals and release of funds, bank failure, and inappropriate first-round selection of target CSOs.
- *Lack of guidance and delayed response from GAVI.* More consistent guidance on implementation issues given DRC's fragile status (that may have been facilitated through in-country presence), might well have mitigated some of the problems and interruptions experienced, and enhanced programme continuity.

If GAVI intends to continue the CSO support in the DRC, presently understood to be for one year (2012) at the current funding level of \$2.3 million, the evaluation team recommends that projected funding levels should be increased and the length of the programme extended to at least three years. This will provide a measure of continuity for the consortium, enabling them to

develop a baseline and do a thorough on-site evaluation after 1.5-2 years of activity. If GAVI cannot commit to more than a one-year commitment, the evaluation team has serious doubts about the Type B programme's utility.

Other recommendations include having a heightened understanding of the fact that the community is at the core of civil society, and that mobilising the community, with or without CSOs, is the key to success. GAVI should transmit funds for the CSO window directly to the CSO consortium, and it should make every effort to harmonise Type B activity with work supported under its HSS window.

## **1. INTRODUCTION**

This is the country evaluation report for the Democratic Republic of the Congo (DRC), prepared as a part of CEPA's 'Evaluation of GAVI's support to CSOs'. The report has been prepared by Eliot Putnam, a CEPA Associate for the evaluation, with input from country consultants Dr. Mapatano Mala Ali and Dr. Désiré Mashinda Kulimba<sup>1</sup>, and CEPA.

### **1.1. Objectives of the country study**

DRC is one of the five country studies of this evaluation.<sup>2</sup> The specific objectives of the country study are as follows:

- to understand the relevance of GAVI CSO support in the country, as well as the alignment of country funded programmes with broader immunisation/health sector plans and priorities, as well as the suitability of various aspects of the programme design;
- to document the country's experience in implementing the programme, including identifying factors that have promoted or impeded effectiveness;
- to collate information on the results achieved through the funding to date; and
- to solicit feedback on the suggestions for improving the effectiveness of the programme going forward.

The country study forms an important source of evidence for our evaluation of the policy rationale and programme design, implementation, and results of GAVI CSO support.

### **1.2. Methodology**

The country study draws on information from: (i) country-level documentation; and (ii) interviews with local stakeholders during a visit to DRC during 2-7 October 2011.

### **1.3. Structure of the report**

The report is structured as follows: Section 2 provides the country context and overview of GAVI support in DRC. Sections 3, 4 and 5 assess the policy rationale and programme design, implementation, and results of GAVI CSO support in DRC. Section 6 provides recommendations on improving GAVI CSO support, based on country-specific experience and feedback.

This main report is supported by annexes on: references (Annex 1); list of consultations (Annex 2); summary results through Type B funding (Annex 3); and a summary of factors impacting effectiveness of the support (Annex 4).

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<sup>1</sup> Prof. Mapatano Mala Ali and Dr. Mashinda Kulimba Désiré were employed through the Kinshasa School of Public Health for the purposes of this consultancy. Professor Mapatano Mala Ali is also Chef de Cabinet to the Congolese Minister of Health.

<sup>2</sup> The other country studies are on Indonesia, Ethiopia, Afghanistan and Pakistan. The CEPA team is visiting the former two countries, and local partners have been appointed for the latter two countries.

## 2. COUNTRY CONTEXT AND GAVI SUPPORT

### 2.1. Brief background on DRC

DRC is located in Central Africa, with an area of 2,345 million square kilometres. It is the second largest country in Africa, after Algeria, with a population currently estimated at 70 million inhabitants. Per capita GDP is estimated to be between \$186 and \$200 per year, one of the lowest in the world. Administratively, the country is divided into 11 provinces and 516 health zones. 71% of the population lives below the poverty line. Children under the age of five years constitute approximately 17.8% of the population.

### 2.2. Health and immunisation

The health system of the DRC is subdivided into the central (Ministerial Cabinet, Permanent Secretary's Office, 13 Directorates and 52 programmes), intermediate (11 health provinces), and peripheral levels (516 health zones) where primary health care, including immunisation, is delivered through health centres and other facilities. The public health system delivers at most 40% of health services nationally, with the remainder taken up by church organisations and NGOs.

EPI is structured the same way as the overall health system, with a central level for policy and decision making. At the provincial level, the EPI programme has developed “antennes”—transitional structures with high cold chain capacity meant for storing and distributing vaccines to health zones and health centres where vaccinations are actually provided.

According to a 2005 UNICEF Multiple Indicator Cluster Survey (MICS), 87% of women aged 15-49 years with a live birth received Antenatal Care (ANC) from trained personnel at least once, and 44% received ANC at least four times from some sort of provider. 74% were attended by a doctor, nurse, midwife or auxiliary midwife at delivery and 75% delivered in a health facility.

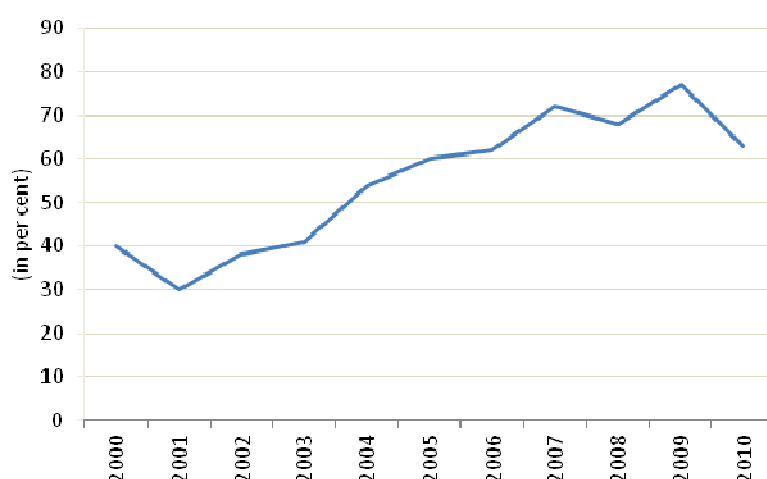
Table 2.1 sets out the 2010 coverage estimates for the key vaccines (with DTP3 coverage in Figure 2.1). Given these figures, it is understandable that the infant mortality rate in the DRC is still high, at 112 per 1000 live births.<sup>3</sup>

*Table 2.1: WHO/UNICEF coverage estimates, 2010*

<b>Immunisation coverage</b>	<b>(in per cent)</b>
BCG	85
DTP3	63
Third dose of polio vaccine	72
Third doses Hepatitis B vaccine	63
Measles-containing vaccine	68
Yellow fever	62

<sup>3</sup> World Bank database (2010)

Figure 2.1: DTP3 coverage rates in DRC (2000-2010), WHO/UNICEF



### 2.3. Role of CSOs

CSOs, especially faith-based organisations, provide health services to hard-to-reach populations, making them key partners for improving health care coverage. A 2008 survey undertaken with Type A CSO funding from GAVI (see below for further discussion) identified 418 CSOs directly or indirectly involved in vaccination outreach and services. Over half were located in the four provinces of Bandundu (84 CSOs), Katanga (64), Kinshasa (57) and Kasai Oriental (57).

NGOs engaged in the health sector are registered under a coordinating organisation known as the *Conseil National des ONGs Oeuvrant dans la Santé (CNOS)*, which serves as the interface between health NGOs and the Ministry of Health. No health NGO can operate in DRC if it is not registered by CNOS. CSOs embrace a broader concept, inclusive both of NGOs and other non-government stakeholders, including community-based organisations.<sup>4</sup>

### 2.4. Overview of CSO and other GAVI support in the DRC

#### 2.4.1. Overall support

GAVI provides assistance to immunisation programs in the DRC through four windows of intervention:

- *New and underused vaccine support (NVS)*. Disbursements for pentavalent vaccine were approximately \$86.55m (2008-12); for pneumococcal vaccine \$33m (2011); for tetra-DTP-Hepatitis B vaccine \$10.35 (2007-08); and for yellow fever vaccine \$17.2m (2003-15).
- *Immunisation Services Support (ISS)*. Disbursements under this category of assistance between 2002 and 2010 totalled \$25.8m.
- *Health Systems Strengthening (HSS)*. GAVI HSS funding attempts to fill operational gaps in the national EPI system, in terms of training, equipment, maintenance and rehabilitation

<sup>4</sup> Section 2 above was provided by Professor Mapatano Mala Ali.



of health facilities, and transport. Between 2007-10, \$41.66m has been provided under this window.

- *Civil Society Organisations (CSO)*. Between 2008 and the present, assistance has been provided by GAVI for both Type A (\$100,000) and Type B (\$5.3 million) CSO activity.

## 2.4.2. CSO Support

The original plan under the CSO window in the DRC was to use **Type A** funding for a national mapping exercise to identify CSOs that could, with targeted support, mobilise communities to make use of public sector vaccination services. Once the mapping was completed, the DRC would avail itself of **Type B** support (as one of 10 pilot GAVI-eligible countries selected to do so), using the more substantial Type B funds to enhance CSO capacity to strengthen EPI interventions in targeted health zones. This would be done through transport and other logistical support for CSOs, ensuring that zonal health centres are properly equipped to handle vaccination services, and training of outreach workers to carry vaccination messages to their communities and supervision of their work.

As it happened, a decision on Type B funding was reached before Type A, and a first instalment of funds (\$2.9 million) disbursed in early 2008. The Type A mapping exercise was not funded until much later in the year (see Table 2.2 below). While the mapping developed a detailed and useful database, it was too late to be of use to the launch of Type B activities. Accordingly, the group of approximately 20 CSOs selected initially to deliver the proposed activities, were primarily international CSOs with limited links with the community. As this approach did not work well, a new 5-member consortium was established to lead the CSO initiative; headed by SANRU and included Catholic Relief Services (CRS), the Congolese Red Cross, the Rotary Association of Congo (ARCC), and CNOS, an umbrella association of health NGOs. The consortium, in close collaboration with the MOH, originally targeted 65 “zones de santé” or health zones, each member taking a group of zones depending on its geographic area of experience. The number of zones for Type B intervention was later reduced to 42, because of funding limitations.

However, each component of GAVI’s CSO initiative had a role to play, and despite less than ideal synergy between programme elements, and numerous interruptions over time, they have achieved partial, if fragile, success.

Table 2.2: Summary on Type A and B support

Type of support	Type A	Type B
Date of proposal submission	5 <sup>th</sup> October 2007	5 <sup>th</sup> October 2007
Date of approval	7 <sup>th</sup> January 2008	1 <sup>st</sup> November 2007
Date of (first) <sup>5</sup> disbursement	30 <sup>th</sup> July 2008	15 <sup>th</sup> April 2008
Total funds approved	\$100,000	\$5,319,000
Amount disbursed (as on July 2011)	\$100,000	\$2,989,000 <sup>6</sup>

<sup>5</sup> Date of first disbursement is for the Type B funds

### 3. EVALUATION OF POLICY RATIONALE AND PROGRAMME DESIGN

#### 3.1. Policy rationale

In the abstract, the policy rationale for GAVI's CSO initiative in the DRC was sound, in that it allowed for both Type A and Type B funding. GAVI's mission is to enhance availability and utilisation of immunisation services, and the DRC MOH frankly admits that its public sector services do not yet have the capacity to do that alone. Further, it is openly cognisant of the fact that a major percentage of all health services in the country are provided by religious organisations, NGOs, and other civil society organisations. For this reason, strengthening the capacity of CSOs, especially those with strong links to the community, to mobilise community awareness and utilisation makes sense to the Ministry.

One does not sense at senior MOH levels the mistrust of civil society that has been known to manifest itself in some other countries. Indeed the mapping exercise with Type A funding was carried out under the personal aegis of one of the most senior MOH officials. Neither do the Ministry and its EPI programme appear to be threatened by organisations such as SANRU, the principal implementing agency for the GAVI CSO initiative, which is an indigenous, church-based organisation widely respected for its competence and leadership. Rather they seem fully behind the CSO initiative. As the head of the Ministry of Health's *Direction des Etudes et Planification (DEP)* said, "This window is a good thing. What we don't do enough is create demand at the community level."

#### 3.2. Programme design

Design of the GAVI CSO initiative in the DRC was flawed in several respects:

- *Sequence of inputs.* As noted, Type B funding was approved and activities commenced before the Type A mapping exercise could take place. It had been expected that the mapping would guide programme implementers and the MOH in selection of CSOs that would benefit from capacity building provided by Type B funds. Because the "map" was not yet available, the initial selection of CSOs for support in the health zones was not well informed and resulted primarily in the involvement of larger, internationally supported NGOs rather than CSOs with a community orientation.
- *Transmission of programme funds.* An intense source of complaint within the CSO consortium is the fact that funds for the CSO initiative are not transmitted directly from GAVI to the consortium. The first tranche of \$2.9 million for Type B activity, disbursed in April 2008, languished for months in the MOH system, and when released was reduced by \$35,000 in fees. A similar fate befell the second disbursement of \$2.3 million. Yet there seems no regulatory requirement that funds be disbursed via the government. This is certainly not the case with many international donors. The evaluation team was told by SANRU that an *aide memoire* has this year been signed between GAVI and the

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<sup>6</sup> The second tranche is pending subject to FMA conditions. Funding for CSOs has been advanced from unutilised HSS funds with Government.

MOH approving direct transfer to the CSO consortium for any future funding approved for this window, a development that would be welcomed by the consortium.

- *Synergy with HSS window.* There are obvious areas of complementarity between GAVI's HSS financing and its Type B funding for support of CSOs. Health zones whose capacity to deliver services has been strengthened through HSS inputs are in a better position to absorb increased EPI activity generated through CSO outreach. Yet of the health zones selected to benefit from support through the HSS window, the evaluation team was told that only 11 were also included in the zones benefiting from CSO support.

### **3.3. Relevance of country programmes funded**

There appears to be no question, either on the part of DRC policy makers or other stakeholders, as to the relevance of the GAVI CSO initiative. Type A support, when it was made available, enabled development of a “map” of CSOs in much of the country that can be of continued use to policy makers. The Type B component has begun to help strengthen the national EPI effort.

## **4. EVALUATION OF PROGRAMME IMPLEMENTATION**

### **4.1. Role of GAVI stakeholders**

Viewed from the perspective of the DRC, it is hard to point to many positive aspects of the role of GAVI's various institutions (Secretariat, CSO Task Team, etc) in implementing the CSO initiative in the country, primarily because of the lack of the Secretariat's in-country presence (as per the GAVI model). Many, if not most, of the programme design and implementation problems referenced in this report might have been mitigated had it been possible for GAVI senior personnel to be in the DRC on a more consistent and extended basis. That might have enabled GAVI, for example, to ensure that Type A and B inputs were appropriately sequenced. It might have permitted more effective negotiations leading much earlier to an agreement whereby GAVI funds could be transmitted directly to SANRU. It might have helped limit the damage from the lengthy interruptions experienced by the programme.

In a highly centralised programme that must keep tabs on activities in all 72 GAVI-eligible countries, it is understandable that no one country should attract undue attention. But for a country of the size, complexity and importance of the DRC, not to mention one that was selected as a pilot for both Type A and Type B funding, more consistent attention on the ground could have helped.

In terms of partnerships within the DRC, GAVI and UNICEF have collaborated effectively and together are largely responsible for supplying and equipping the national EPI programme. GAVI has supplied most of the new and/or expensive vaccines, UNICEF the more routine vaccines, and both have contributed to strengthening the national cold chain. In terms of the CSO programme, the evaluation team was not made aware of any specific role of GAVI Partners in country (WHO and UNICEF).

### **4.2. Country implementation**

#### **4.2.1. Type A support**

Type A support in the DRC was used exclusively for the mapping exercise. As previously noted, this funding was not approved until after the Type B programme was funded, and the mapping activity was not completed until well after Type B CSO activity was launched. Thus the key objective of providing a "map" against which to select CSOs for assistance was not met, and the first group of CSOs selected for Type B support proved to be unsatisfactory.

The team responsible for the mapping noted that the \$100,000 allocated by GAVI for the process was insufficient for a country as vast and transportation-challenged as the DRC, and they were thus unable to fully complete the survey. But once funding was approved, they were able to create a database of 418 CSOs from around the country, one that provides detailed information on each CSO's mission, areas of competency, geographical reach, etc. When the project consortium determined that they needed to select a new group of organisations for Type B project support, they used the database, along with advisory support from CNOS, to select five CSOs in each of the 42 health zones covered by the project, emphasising those with demonstrated ties in the community.

#### 4.2.2. Type B support

The SANRU-led CSO consortium has accomplished much under difficult and often uncertain circumstances. The choice of the five members of the consortium spans a wide range of interests, competencies and geographical expertise and was appropriately strategic. Collaboration among members appears strong and this is important because the consortium has had to weather significant delays and major interruptions to its work.

Support for CSOs with Type B funding did not commence until September 2008, after long delays in the release by the MOH of funds disbursed by GAVI in April. CSO support activities in target zones ran successfully until April 2009, when payments from the MOH were again held up due to GAVI's requirement of the TAP/ FMA fiduciary checks.<sup>7</sup> GAVI asked the MOH to transfer an unused portion of HSS programme funds to the CSO account (as these could not be used for HSS until the end of the fiduciary checks). However, there were further delays in release of funds by the government, since GAVI did not approve of the fiduciary agency selected and when funds were finally transferred, the bank handling the SANRU account went bankrupt. The result was a year and a half of interruptions before the Type B programme could resume its work in November 2010. In the interim, members of the consortium did what they could to maintain activities with other funds, but any significant momentum for the programme was lost.

Since that time the programme has functioned in 42 health zones (down from the original 65), with a new group of CSOs. With the help of the mapping conducted under Type A funding, the latter were selected, five per zone, for their demonstrated links to the community. The programme has provided logistical and technical support to CSOs, and through them to communities, raising awareness of the importance of vaccinations and mobilising community residents' use of vaccination services.

But just as progress is being made, activities will be interrupted once again, as funding approved for the Type B initiative has been exhausted. The evaluation team was told that all budgeted funds will have been dispensed to consortium members by October 2011. As per footnote number 6, these funds were advanced from unused HSS resources, pending release of the final tranche of approved Type B funding. However, the effect is the same, i.e. resources available to the programme have all been expended,

The evaluation team was informed during the country visit that GAVI has asked SANRU and its consortium to submit a proposal for funding for 2012 at a subsistence level of \$2.3 million. But while extending support will be welcome, its limitations will only cause continued uncertainty as to the future of a programme that has already been forced to proceed in debilitating fits and starts.

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<sup>7</sup> The reasons for GAVI's holding back of funds were however not completely clear to countries.

## **5. EVALUATION OF PROGRAMME RESULTS**

### **5.1. Evidence on results**

#### **5.1.1. Type A support**

Although delayed, as previously described, the mapping exercise funded under Type A resulted in the creation of an important database of 418 CSOs from around the country. It was subsequently used in the selection of a new group of CSOs in Type B target zones, when the first group selected proved to be inappropriate. The database now exists and can be used whenever detailed information on Congolese CSOs involved in promoting healthcare in the community is desired.

#### **5.1.2. Type B support**

There are no detailed studies reflecting the impact of the Type B programme in target zones in terms of increased vaccination utilisation over time, the ultimate objective of this initiative. The programme has been active for too short a time to generate reliable impact data. However, figures verified by the EPI programme and available from SANRU do show modestly encouraging results, as illustrated in Annex 3. For example:

- Some progress was made with regards to providing technical, logistical and financial support to zones, however this support was provided to fewer zones than proposed.
- In zones targeted for Type B support, 83% of children under 2 years of age received hepatitis B and measles vaccinations in 2009, the first year of project activity. However, this figure dipped to 78% during the funding interruption of 2010; but returned to 89% in the first quarter of 2011 after funding was resumed.

Other indicators showed progress as well, although they did not reach projected goals. In all, figures in Annex 3 indicate some modest results, that are positive enough to warrant continued effort and more detailed analysis.

## 6. RECOMMENDATIONS

The following recommendations are offered in the assumption that GAVI intends to continue the CSO support pilot project in the DRC. Certainly the MOH and its EPI programme see its potential value and hope it will continue. However, if such is the case, *projected funding levels should be increased and the length of the programme extended to at least three years*. As it is now, for reasons described above, the CSO support has not had the chance to get off the ground, and a one year extension at level funding promises to have more impact. The CSO consortium needs to have the confidence that it can plan on a period of activity of reasonable length, one that will enable it to develop a baseline and do a thorough on-site evaluation after 1.5-2 years of activity. If GAVI cannot see its way to more than a one-year commitment, the evaluation team has serious doubts about the Type B programme's utility. In a country whose needs for support in the health sector are so large and complex, small bits of funding, erratically provided, are not helpful.

In the event that the programme does continue, the following should also be offered:

- *Emphasise the community.* The community itself is the essential element of civil society, the ultimate CSO. Capacity building activities may be conducted through local CSOs such as agricultural groups or women's associations. But they are also carried out directly by *relais* (outreach workers) attached to health centres who circulate in surrounding villages advocating the importance of vaccinating children and providing information on available services. Type B funding should be aimed at mobilising communities to ensure vaccination of unreached children.
- *GAVI should transmit Type B funds directly to the consortium.* As noted, the evaluation team was told that an *aide memoire* had been signed between GAVI and the DRC government approving what in fact should be a routine process. Direct funding has been a top priority for the Type B CSO consortium from the beginning.
- *Harmonise Type B activity with the HSS window.* Funds for Type B activities should not be incorporated in the HSS budget, which is cleared through the MOH. But the activities themselves, in terms of the health zones in which they take place, should be coordinated as much as possible with HSS support activities so that one can complement the other. If this means seeking out CSOs in different zones, the map prepared with Type A support exists to help that process.

## **ANNEX 1: REFERENCES**

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## ANNEX 2: LIST OF CONSULTEES

Table A2.1: List of consultees

Stakeholder category	Name	Position/Organisation
CSO Consortium	Liliane Diatezulwa,	Consortium Project Manager, SANRU
	Benoit Mibulumukini	M&E, SANRU
	Dr. Adrien N'siala	SANRU
	Dr. Valentin Mutombo	Association des Rotary Club du Congo (ARCC)
	Dr. Nicole Shabani,	Catholic Relief Service
	Dr. Jean Faustin Balelia,	Croix Rouge de la RDC (CRRDC)
	Nestor Mukinay,	CNOS
	Emmanuel Nyabenda	
Ministry of Health	Dr. Paul Lame,	Directeur Adjoint, Programme Elargi de Vaccination (PEV)/(EPI)
	Dr. Kalambayi,	Directeur, Direction des Etudes et Planification (DEP)
UNICEF	Pierrette Vu Thi,	Représentante
	Karl Friedrich Stahl,	Logistics Specialist
WHO	Yolande Veio	Programme Officer
European Union	Dr. Bart Callewaert,	Gestionnaire Programme Santé
Health and Development Commitment (NGO)	Didier Molisho Sadi,	MD, Administrateur

### ANNEX 3: DESK REVIEW OF RESULTS FROM TYPE B FUNDING

This annex provides a summary of the progress reported in the APRs against the activities and expected results detailed in the DRC country proposal for Type B support. It is entirely desk-based, although the results were largely reinforced by our in country consultations.

**It should be noted that this draft analysis is based entirely on reported progress on indicators by countries, and CEPA has not sought to verify/ validate any of these (and indeed this is not possible given the mandate and timelines of our evaluation). We have however used our judgement, based on the information provided and country consultations, to present a summary status on the progress achieved.**

#### *Structure of analysis*

We have structured our analysis as follows:

- We present two tables – the first focusing on activities and outputs, and the second on outcomes and impacts. We have tried to construct these in a consistent manner following CEPA’s results hierarchy, given the varying presentations across countries.
- These tables do not intend to map the progress against *all* activities undertaken, but rather, provide an overview of the *main* country level activities and progress achieved.
- We have tried to map both activities that can be assessed quantitatively (e.g. number of trained health workers) as well as activities that can be assessed based on whether they have been completed or not (e.g. conducting a baseline survey).
- We have attempted to summarise the extent of progress achieved by the following categories: “Considerable progress”, “Some progress” and “Unknown”<sup>8</sup> – however this represents our subjective opinion based on the information in the proposal and APR documents available, and may not be completely accurate given the poor quality of information contained in these documents (see limitations below).

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<sup>8</sup> Our categories for summary progress are self-explanatory, however please note that where it is not clear either (i) what progress has been achieved; and / or (ii) the context for the progress (i.e. where targets or milestones are not noted), we have marked the progress as “unknown”, despite APRs reporting on the progression of activities.

### *Limitations*

There are a number of limitations to our analysis, as detailed below:

- The latest APRs we have been able to analyse was the 2010 APR. It is likely that further progress will be reported in future APRs (especially 2011, given ongoing funding support in the countries).
- Activities, outputs, outcomes and impacts (baselines and targets) are generally not clearly laid out in the country proposal and APRs. For example, sometimes these are noted on a general basis rather than defined by specific targets and timelines. Also, the context for some of these results is not clear – i.e. what part of the problem are these activities and their results aiming to solve?
- It is often unclear how the results hierarchy, or logical framework, has been constructed. For example, activities proposed do not always match outputs or outcomes proposed/ reported.
- As timelines and other factors have changed during the implementation of activities, target timelines, and sometimes the targets themselves, have changed.
- It is difficult to track progress along the results hierarchy as the information in the APRs does not always relate directly to the proposals (including inconsistencies between subsequent APRs).
- While we recognise that outcome and impact indicators may not be possible to measure as part of this evaluation, often they are not reported in the APRs. Where this is the case, we have inserted the summary status ‘unknown’ into the tables.
- The categorisation of summary progress is based on our subjective opinion – and is not directly comparable across countries, as the level and quality of information varies considerably across countries.

### *Country level summary*

The tables below provide a work-in-progress summary for DRC:

Table A3.1: Progress on outputs

Proposed activities	Progress against outputs	Summary status
Technical, logistical and financial support to 65 Health Zones and EVP branches	In 2009, 65 Health Zones received financial support for logistics and equipment to undertake immunisation activities	<b>Some progress, but number of Health Zones involved reduced to 42 from original 65</b>
Training of CSOs and health workers to deliver immunisations	The training of Red Cross and RECO volunteers made it possible to immunise an additional 22,180 people between 2008 and 2009	<b>Progress has been made but accurate figures are elusive, probably unreliable</b>
Training of health workers in EVP management	150 health workers were trained in EPI management	<b>Unknown</b>
Strengthening the partnership and coordination of CSOs	4 supported CSOs participated in health sector coordination meetings in 2009 CSO coordination meetings were held in 2009 and 2010 A consortium of the main implementing CSOs has been established	<b>5-member consortium is functioning effectively. Five community-oriented CSOs have been selected for support in each of 42 health zones of project activity.</b>
Support advocacy and social mobilisation activities at the national and provincial levels	Advocacy activities were undertaken at the national and provincial levels in 2009	<b>Progress not clear, but activity limited. Principal focus is on activity at zonal level.</b>
Providing financial assistance to local NGOs working in the selected Health Districts for their activities	20 CSOs were financed in 2009 to support immunisation service delivery These CSOs, subsequently deemed to be insufficiently community-oriented, were replaced by five CSOs with strong community links in each of 42 Health Zones Management tools and equipment were provided to support the CSOs undertake their activities	<b>Stops and starts, but eventually some progress</b>

*Table A3.2: Progress on outcomes and impacts*

Proposed outcomes and impacts	Reported progress	Summary status
DTP3 immunisation coverage raised from 74% to 90% in 65 Health Districts	In 2009, DTP3 coverage reached 83%. Due to a lack of funding, in 2010 this fell to 78%, but rebounded to 89% in first quarter of 2011.	<b>Some progress</b>
Measles immunisation coverage raised from 74% to 90% in 65 Health Districts	In 2010, coverage was recorded at 82%.	<b>Modest progress, despite interruptions</b>
TT2+ immunisation coverage raised from 71% to 90% in 65 Health Districts	In 2010, coverage was recorded at 80%.	<b>Modest progress, despite interruptions</b>

## ANNEX 4: FACTORS IMPACTING EFFECTIVENESS

There are a number of factors (both positive and negative) which have affected the effectiveness of the CSO programme in DRC. These factors are summarised in the table below. Positive factors are indicated by ‘+’ while negative factors are indicated by ‘-’ and factors which have been viewed differently by different stakeholders are indicated by ‘±’.

*Table A4.1: Summary of factors affecting effectiveness*

Type	Factors
GAVI-specific factors	<ul style="list-style-type: none"> <li>– GAVI’s institutional model was viewed inefficient in the country because of the lack of in-country presence</li> <li>– No specific role of GAVI Partners in country</li> <li>– Disbursement delays on account of FMA checks</li> <li>– Small size of funding</li> </ul>
Country-specific factors	<ul style="list-style-type: none"> <li>+ Major percentage of all health services are provided by religious organisations, NGOs, and other civil society organisations</li> <li>+ Favourable government-CSO interaction</li> <li>– Delays due to misuse of GAVI funds and bankruptcy of SANRU’s bank</li> </ul>
Programme-specific: Type A	<ul style="list-style-type: none"> <li>+ Creation of database helped select a new group of organisations for Type B support</li> <li>– Insufficient funds to conduct comprehensive mapping exercise</li> </ul>
Programme-specific: Type B	<ul style="list-style-type: none"> <li>– Short implementation period and inefficient sequencing of Type A and B support</li> <li>– Channelling of funds through the government</li> <li>– Complementarity between GAVI’s HSS financing and its Type B support to CSOs has not been maximised</li> <li>+ Strong collaboration between the members of the CSO consortium in implementing the Type B support</li> </ul>