GAVI Health System Strengthening Support Evaluation

RFP-0006-08

Democratic Republic of Congo Case Study

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Acronyms and Abbreviations

AGF	Agence de Gestion Financière
APR	Annual Performance Report
CAG	Cellule d'Appui à la Gestion (Management Support Unit)
CNP	Comité National de Pilotage (NCS)
CCIA	Comité de Coordination Interagence
DAF	Directorate of Administration and Finance
DEP	Direction of Studies and Planning (Direction d'Etudes et Planification)
DHS	Demographic Health Survey
EDF	European Development Fund
EPI	Expanded Programme for Immunization
FEDACAME	Federation for Procurement of Essential Medicines (Fédération des Centrales d'Approvisionnement en Médicaments Essentiels)
FMA	Financial Management Agency
GAR-SS	Groupe d'Appui au Renforcement du Système de Santé (Health Systems Strengthening Support Group)
GIBS	Health Sector Donor coordination body
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HSSS	Health Systems Strengthening Strategy
HZ	Health Zone
IACG	Inter-Agency Coordinating Committee (CCIA)
MDG	Millennium Development Goals
MPH	Ministry of Public Health
MPH	Minister of Public Health
NGO	Non-Governmental Organisation
NSC	National Steering Committee (CNP)
PBF	Performance Based Financing
PMU	Programme Management Unit
SNIS	Système National des Informations de Santé (Health Management Information System)
ST	Secretariat Technique (TS)
TS	Technical Secretariat (ST)
UNICEF	United Nations Children' Emergency's Fund
WB	World Bank

WHO	World Health Organisation
ZCA	Zonal Conseil d'Administration (Zonal Central Bureau)

Summary of key findings, conclusions and recommendations

This summary of the Democratic Republic of Congo (DRC) country case study answers the first two GAVI HSS evaluation questions, namely:

1. What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
2. What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

The GAVI HSS proposal design

The GAVI HSS proposal design was very much country driven, responding to the analysis and needs identified in the national Health System Strengthening Strategy (HSSS) 2006. In fact, the GAVI HSS funding window was seen as the means to operationalising the DRC HSSS and the proposal was developed accordingly. Proposal development also followed an inclusive process – all key stakeholders (representatives of government, donors and non-profit implementers) had the opportunity to comment, input and review the proposal.

The national HSSS and the corresponding GAVI HSS proposal is quite strategic in outlook and orientation – both have a vision of the results that need to be achieved for strengthening the health sector and are in line with the DRC PRSP. However, not enough thinking was done at the outset about how either the HSSS or the GAVI HSS proposal were going to be implemented and this has had a knock on impact on national HSSS and GAVI HSS implementation. The 'working hypothesis' in the HSSS was that US$3 per capita would be needed for financing the national HSSS interventions to strengthen health zones, which are pivotal to improving health service delivery in DRC. This figure is not referred to or used in the GAVI HSS proposal, nor in other HSS proposals. It is fair to say that the Ministry of Public Health still has limited knowledge of how much it will cost them to implement the HSSS in full, though the experience to be gained from implementing GAVI HSS will be invaluable in learning the true costs.

Programme implementation

The overall implementation of the national HSS strategy, and therefore GAVI HSS funded aspects, is still in its start up phase. The Ministry of Public Health has put appropriate emphasis on getting systems and procedures in place before becoming to heavily involved

in implementation. GAVI HSS funding has helped the MPH to think through how best to separate different functions in the health system (planning, financial management, monitoring, etc) to help strengthen accountability overall. Taking time to do this should continue to be supported as having robust systems and procedures will remain very important in DRC, with its chequered history of governance and accountability problems.

One systems area that has caused significant delay in implementation is the setting up of a Financial Management Agency (Agence de Financement – AgeFin). The tendering, selection and contracting of the AgeFin has taken far longer than the government expected and so agreement was reached with partners in February 2009 to put in place an interim AgeFin so that funds could begin to flow.

On the positive side, the MPH has also made good progress with initiating health zone level planning in the 65 GAVI HSS health zones, working through various NGO partners who already support health zone structures and systems. It is expected that all 65 health zones will have submitted their health plans to provincial medical offices by the end of June, who will then develop provincial health plans. The planning process was to have been informed by a situation analysis study in each of the target health zones, which has not been done because of the problems with setting up the Financing Agency.

Monitoring

The results framework for GAVI HSS is well aligned with the Health Systems Strengthening Strategy results framework. It is also in line with the coordinated and harmonized vision of M&E under HSSS as GAVI HSS activities will be monitored using the National Health Information System (SNIS). However, the results framework may be missing some of the critical contributions that GAVI HSS funding could be making to the DRC health system (i.e. contributions less tangible than immunisation progress or outputs related to decentralised planning mechanisms.) These critical aspects include, amongst others a) increased alignment and harmonisation of all partners with the national HSS strategy and systems and b) the effective functioning of governance and accountability mechanisms that support the implementation of the HSS strategy. The MPH and partners will need to review how best to capture these aspects as part of the results framework as these will provide useful lessons for other post-conflict countries wishing to develop a more coherent health system.

This being said, there are still important challenges associated with harmonizing the various M&E frameworks and systems of externally funded programmes' with the HMIS. The degree

and effectiveness of harmonization and alignment efforts will need continued consideration and effort on the part of the MPH and partners

Harmonisation and alignment

As mentioned earlier, the GAVI HSS proposal is well aligned with HSSS, and indeed critical to the implementation of the national HSS strategy. GAVI HSS has been catalytic in uniting key stakeholders in the health sector around the HSSS, including the DRC government itself.

Significant willingness and intention exists among partners to harmonize plans, procedures and pool funds in line with the national HSS strategy (and eventual next phase health sector strategy). Implementing this in practice will remain a challenge. Fortunately, due to GAVI HSS funds, there are now coordination and accountability structures in place that will allow for continued dialogue and debate amongst all the different health sector partners.

Some of the key challenges to effective harmonization are likely to include the time needed to achieve full harmonization of all main health stakeholders and the potential resistance of some partners at the operational level who still have organizational obligations to track results versus funding for their specific programmes rather than using national monitoring systems.

GAVI HSS is complementary to other partner funds and efforts. This is clear both in the design of the proposal interventions and also evident in the planning process initiated using GAVI HSS funds, which has been designed to document and leverage partner interventions and funds at zonal, provincial and central levels

Finally, through improving the provision of curative services, GAVI HSS promotes integration of preventative services such as immunization.

Management

Strategic level oversight is well developed, though needs to become more routine. So far the main strategic oversight body, the Conseil National de Pilotage (CNP) has only met once. The Secreteriat Technique (ST) and technical working groups (commissions) do not have a regular schedule of meetings as yet, but have been set up and membership agreed between all partners. These structures are needed to help guide the technical quality of HSS interventions. As yet there is no commission for advising on and monitoring human

resource issues. This is like due to the fact that the HR issues in DRC are still considered too politically sensitive to tackle in the open. However, all stakeholders interviewed during this evaluation agreed that human resource rationalisation and reform are vital to the successful implementation of any health system strengthening strategy. The issue can no longer remain the 'elephant in the room' but needs a dedicated group to work through the possible permutations of human resource reform strategies.

Effort is also needed to improve communications between the central, intermediary and peripheral levels. Several key stakeholders felt there are insufficient information updates from DEP/ CNP around the status of implementation of GAVI HSS and the national HSS strategy more generally.

The fact that management and monitoring systems were not in place when the proposal was approved should have triggered the GAVI Secretariat and the IRC to consider a more phased approach to supporting HSS in DRC. The proposal is explicit that various institutional arrangements need to be set up, and concerns about management capacity were raised directly with the IRC by the World Bank. The experience from DRC should provide useful lessons for the approval and monitoring of future HSS grants to equally challenging countries.

Operational management is now needed as a matter of urgency so that day to day and more routine monitoring is possible. The Direction d'Etudes et Planification (DEP), which currently assures much of the operational management of the HSS strategy needs to delegate operational authority to the newly set up interim Cellule d'Appui a la Gestion and the GAVI HSS focal points therein, while supporting this new structure to ensure that its staff have the capacity and capability to accelerate national HSSS implementation.

Programme results

As GAVI HSS funded activities remain very much in their start up phase there are no real results to report. However, the government and its partners have made considerable progress in getting much needed systems and procedures set up and in place, so that from 2009 onwards an acceleration in implementation should be expected throughout all levels being supported by GAVI HSS. The IRC will need to do a close examination of the 2009 APR to satisfy themselves that larger amounts of GAVI funds are being dispersed from central levels to support the implementation of health zone and provincial plans. At the same

time there should be some indication that support has started flowing for the implementation of human resource for health strengthening activities.

Programme results related to performance based payments may be seriously hampered by current staffing arrangements at health facility and central level, where the numbers of staff are based more on political expediency and not on need. Without human resource reform any notion of improving staff performance through increased payments to teams will be meaningless as the amounts received by each individual is likely to be minimal. Furthermore little consideration has been given to the financial sustainability of any performance based financing (PBF) programme in DRC, though most development partners are providing PBF support, albeit in a fairly ad hoc fashion. There is no national PBF strategy (at least that we could find) and PBF is not featured in the national HSSS, which emphasises the much greater need for human resource reform.

Conclusions

GAVI HSS interventions are well aligned and appropriate for assuring the implementation of the DRC Health System Strengthening Strategy. Throughout the two years since the GAVI HSS proposal was approved the MPH has shown a high degree of strategic thinking and pragmatism. Successful reform in the MPH has so far been evolutionary, and therefore sometimes very protracted. As emphasised by all stakeholders interviewed it will be extremely important that the MPH ensures that all necessary systems and procedures are in place, well communicated and understood by all stakeholders concerned, before implementation begins in earnest. The flexibility in GAVI HSS funding, so far, has helped to take forward much needed reforms in the same mould and could have wide reaching impact on the health system as a whole if given enough time.

That being said, the experience of GAVI HSS in DRC offers substantial challenges to how GAVI works more generally. The key areas that need consideration are:

- **Lack of country presence and knowledge**: The GAVI model of treating all countries as though they have the same capabilities and applying a 'one size fits all' model of proposal review and programme monitoring does not work in countries like DRC where the political and economic environment remains hugely problematic. At the very least fragile state countries such as DRC (at least as it was in 2006) warrant greater examination through country visits and discussions with in-country stakeholders. If this

had been done, it is likely that GAVI would have opted for a more phased approach to funding disbursement, which would not have hampered the flexibility that is so appreciated by DRC stakeholders.

- The allocation of two years' worth of funding within two months in the first year of operation seems particularly ill-advised given the constraints indicated in both the proposal and the background documents.
- The indicators being used to monitor GAVI HSS progress do not measure some of the significant changes that GAVI HSS could be supporting in DRC, and may therefore give a very limited picture of what has been achieved due to HSS funding in the country. More appropriate indicators could be more health systems ones that look at whether the minimum package of activities is being offered at all health centres, health sector financing and health system governance, all areas being supported through GAVI HSS.
- GAVI HSS in DRC, as in other countries, is providing funding for performance based financing without any clear indication of how PBF is to be sustained or absorbed into improved salaries and incentives more generally. This is particularly problematic in DRC where state funding of the health sector is astonishingly low and public sector reform is progressing very slowly as well.
- With the very slow start up of GAVI HSS activities in DRC there is no possibility that the MPH will be able to use all the GAVI funding applied for within the programme period. No one, neither GAVI nor the MPH, have started discussions on extending the period of the programme and the implications of doing this on the 2012 evaluation.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Democratic Republic of Congo (DRC) in June 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etc.) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

1.2 Brief conceptual framework of the Evaluation

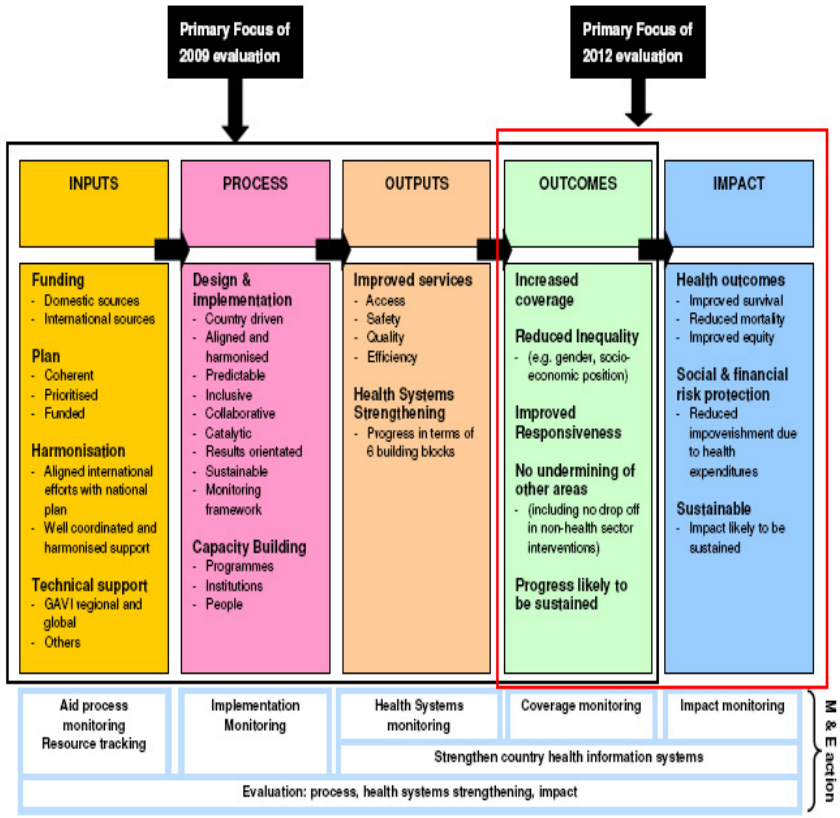
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window;
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.);
3. To enhance the quality of the 2012 evaluation.

It is important to note given the little time elapsed since the first HSS applications were approved in 2006 that this evaluation – the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in

grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the "right" bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Country Case studies

All 11 countries included for in-depth review underwent at least one country visit by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.[1] In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were able to count on the invaluable support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study - led by the JSI/InDevelop-IPM covers very similar areas (albeit from a different angle) to those aimed at in our HSS Evaluation study, so it was highly synergistic for us to be able to use the Tracking Study guidelines and their extensive network of contacts and country knowledge for the purposes of our own evaluation study. To all members of the Tracking Study team including their country collaborators we wish to express our most sincere thanks and appreciation for their generous collaboration.

In DRC as in other countries the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called "Focal Points" based at either the World Health Organisation (WHO) or UNICEF. The JSI/InDevelop Tracking Study team for DRC also provided names of key stakeholders to interview, and were happy to be interviewed themselves prior to our mission. The programme of interviews and people met can be found in Annex 1.

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of DRC the country visit took place between the 7th and 16th June 2009. This relatively short visit was sufficient given that the GAVI HSS activities are only just beginning to get off the ground and due to information provided in interviews with the TS team. Meetings were divided between interviews with key stakeholders and informants in Kinshasa and interviews with provincial and zonal health staff

[1] The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

in Kinshasa Province, since the focus of GAVI HSS funded activities is at all three levels (central, provincial and zonal).

1.4 Limitations of the Study

All stakeholders proved generous with both their time and sharing of key documentation. During the short visit, the evaluation team were able to meet with all key stakeholders they intended to at central government level. The limited time and logistics, as well as the spread of GAVI HSS activities at decentralised levels meant that we were only able to receive a cursory view of how GAVI HSS supported activities have been implemented outside of Kinshasa. We were able to get some helpful information from the NGOs that are helping with zonal level planning, but acknowledge that the study would have been more complete if zonal and provincial staff from other parts of the country could have been interviewed, as well as a larger group of NGO and private sector health providers.. The 2012 evaluation will need to give due consideration to how to best evaluate the GAVI HSS programme in countries the size of DR Congo in order to ensure that decentralised levels are well represented.

1.5 Acknowledgements

We would like to thank the Ministry of Health in DRC, in particular Dr. Hyppolite Kalambay Ntembwa, Director, Etudes et Planification and his staff for the support received for this evaluation study. Thanks are also expressed to WHO and UNICEF, and to all key informants that we interviewed. The full list of people met for this study is included in Annex 1.

2 Snapshot of the DRC health system

2.1 Progress towards MDGs

The total population of DRC is around 65 million people. It is a large country, covering roughly the same land area as western Europe. The modern history of DRC is a tale of corruption, war and almost no investment in any area of development. The lack of investment in infrastructure in particular poses enormous challenges for managing the health needs of a highly dispersed population. This is compounded by outbreaks of violent conflict in eastern Congo over the last few years, making access to health services for both supply chains and for local communities very difficult. These challenges mean that DRC is off-track for meeting its MDG targets, with some indicators actually going in reverse.

The below table presents a summary of progress against each of the health MDGs:

MGD	MDG Monitor Current Status[2]	DFID Assessment of Current Status[3]
Goal 4: Reduce child mortality TARGET: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Off track	The DRC is severely off-track in meeting this MDG: In 2005, deaths of children under the age of 5 numbered 205 per 1,000 live births, the same rate as in 1990.
Goal 5: Improve maternal health Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	Off track	The DRC is unlikely to achieve this goal: in 2005, it was estimated that, for every 100,000 live births, 1,100 women died shortly before, during or shortly after childbirth.
Goal 6: Combat HIV/AIDS and other diseases TARGET: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Possible to achieve if some changes are made	With 3.2% of the population aged 15-49 living with HIV/AIDS, it is unlikely that the DRC will achieve this MDG.

[2] MDG Monitor: http://www.mdgmonitor.org/country_progress.cfm?c=COD&cd=180 Accessed 13 June 2009

[3] DRC is a long way from meeting any of the Millennium Development Goals. In addition, robust statistics are generally unavailable so any progress there has been is difficult to track http://www.dfid.gov.uk/Where-we-work/Africa-West--Central/Congo-Democratic-Republic/Key-facts/ Accessed 13 June 2009

In 2004 a review of progress against MDG targets indicated that progress against the health related targets were particularly weak. The 2007 DRC Demographic Health Survey shows that improvements have been made in some areas, yet it also clearly indicates a need for continued and significant efforts to achieve progress towards meeting MDG targets:

- **Infant & child mortality:** During the period 2002-2007 results showed that 92 (*126 in 2001*[4]*)* out of 1000 children did not reach their first birthday and 62 (*213 in 2001*[5]) out of 1000 did not reach their fifth. Only 28% of infants had completed a level of vaccination according to the recommended schedule before reaching 12 months; one in five children under the age of five (20%) received no treatment for diarrhoea at all; and only 19% of children under the age of five had slept under a treated mosquito net the night before the survey (malaria accounts for estimated 25-30% child mortality[6]).
- **Maternal mortality:** During the 4 years preceding the 2007 survey 549 (*1289 in 2001*[7]) women died out of every 100,000 live births. This means that one in 29 women in DRC die due to maternal related causes.
- **HIV/AIDS and other diseases:** National HIV prevalence was recorded at 1.3% (although this is the lower interval of prevalence), compared to *8% in 2001 and 3.8% in 2003-4*[8]. Less than a third (28%) of all households in DRC possesses at least one mosquito net, (regardless of whether it is treated or not); and less than one household in ten possesses at least one treated net. This, despite the fact that malaria remains one of the primary causes of death among young children and pregnant women[9]

While there is no doubt that the DRC faces an uphill struggle, in the last few years there have been promising signs. A government of national unity came to power in 2003, while a new two chamber parliament was established in 2004. National elections passed smoothly in 2006 under supervision of independent election monitors. Despite rebel efforts to derail agreed peace agreements in the east of the country, the DRC government has managed to negotiate what appear to be peace agreements that are holding. As the security situation begins to settle there is growing space for inward investment into the country and the chance to make real in-roads into the long list of problems that have been accumulating for the last forty years.

[4] Objectifs du Milénaires pour le Développement; Rapport National de suivi de progrès pour la République Démocratique du Congo 2004
[5] ibid
[6] WHO Democratic Republic of Congo Country Profile, 2005
[7] Objectifs du Milénaires pour le Développement; Rapport National de suivi de progrès pour la République Démocratique du Congo 2004
[8] ibid
[9] WHO Democratic Republic of Congo Country Profile, 2005

Some of the main health indicators in DRC provide an overview of the scale of work that needs to be done:

Table 1 Selected Indicators for Morbidity and Mortality in DRC[10]

Indicators	MICS-2 2001	DRC- DHS 2007	Source
HIV&AIDS Prevalence	4,2%	1,3%	UNAIDS-WHO Epidemiological Factsheet, 2004
Prevalence of acute malnutrition	16.1%	10%	MICS 2-2001
Vitamine A deficiency	61.1% children aged 6 - 36 months	-	PRONANUT – 1998
Anaemia	55 % children under 5	-	PRONANUT - 2000
Infant Mortality Rate	126 per 1000 live births	92 per 1000 live births	MICS 2-2001
< 5 mortality rate	213 per 1000 live births	62 per 1000 live births	MICS 2-2001
Maternal mortality rate	1.289 deaths pour 100.000 live births	549 per 100.000 live births	MICS 2-2001

2.2 The Health System Structure and Financing

The Health System Structure

The organisation of the health system is decentralized in DRC, with primary-care and first referral services integrated within the health zones (zones de santé). The health zones cover population of approximately 110,000 per zone. In the 1980s, DRC was a global leader in health reform focusing on integrating primary care and referral services at the Health Zone (HZ) level.

In 2001 the Government increased the number of Health Zones from 306 to 515, the strategy being to increase the geographical coverage of referral services, since each HZ was to have a referral hospital. Above the level of the HZ, the administrative hierarchy includes Districts, Provinces and MOH central headquarters. Recently, however, Districts were abolished in favour of Provinces; with the number of administrative Provinces increasing from 11 to 26.

Due to the lack of government financing over the last decade, Health Zones and facilities have been operating with considerable autonomy, although MPH structures have retained administrative control, particularly over human resources. Many facilities became de facto

[10] From Plan Pluri-Annuelle Complet du PEV: 2008 – 2012. Gouvernement du RDC, Kinshasa 2008

privatized, relying on patient fees to pay staff and operating costs, and providing 5% to 10% of total fees collected to provincial and central levels to support MPH operating costs. The practice of paying a percentage to higher levels ensured that there was no incentive to rationalise or limit the number of facilities or providers, which has led to a severe decline in the quality of care.

It is estimated that 30% of facilities are operated by religious groups who have traditionally worked in partnership with MPH structures. This partnership has facilitated relations between the MPH and international non-governmental organizations (NGOs) financing personnel and operating costs, particularly at the level of the Health Zone. Private-for profit providers may count for as much as 60% of service provision, but this has been hard to estimate as only a percentage register themselves as such with the state and the boundaries are blurred between what constitutes services provided publicly or privately (e.g. many providers operate as both). A key problem lies in the quality and regulation of private sector *for*-profit services. Unlike the NGO sector that has engaged with and contributed to the development of the National Health Sector Strengthening Strategy, the private for-profit sector has not been actively involved. For-profit players are fragmented and not represented as a homogenous group with one focal point representing all their interests. Therefore interfacing with the Ministry of Public Health is a challenge and an obstacle for engaging the for-profit sector in HSS dialogue. The MPH recognises this as a particular challenge as the private for-profit sector is providing unregulated health services with un-trained health professionals or 'traditional healers', providing health services of questionable quality.

Within the Ministry of Health itself, a restructuring process is underway to reduce the current thirteen technical 'Directions' into six. It is hoped that this will lead to better coordination and involvement between different Directions. The restructuring process is expected to be carried out during 2009.

Financing of Health in DRC

Households are the primary financier of health services in DRC. The 2006 HSSS estimated that out-of-pocket expenditure funded up to 70% of total health sector costs. In 2001, less than 1% of the government budget went to the health sector. However, since 2002, the government Interim Poverty Reduction Strategy Paper (IPRSP) committed to allocate at least 15% of the national budget to the health sector. The proportion allocated to health in the government budget has increased dramatically from less than 2% in 2002 to 7% in 2004.

In reality, however, only a portion of this budget has been executed. In 2004, estimated government health spending was around US$25 million compared to US$80 million budgeted. Increased external support (US$200 million annually expected in the coming years) could reach US$ 4 per capita annually, raising the per capita spending to US$16. The bulk of resources from external support is specific to diseases, raising the risk of continued 'verticalization' of the system. In terms of resource allocation and management, there is a need to get Health Zones more fully involved in these decisions in order to improve their ownership and as the development of their capacity in these areas.

2.3 The response from the health system

The health sector has had a national plan in place from 2000, due to end this year (2009). A number of Global Health Initiatives began to support health programmes in DRC in the early 2000's. Many commentators indicated that, while the injection of new resources was welcome, this new funding also caused significant disruption to an already weak health sector. The main criticisms of these programmes were that they are highly vertical in nature, putting large amount of funding into specific programmes. In addition, often these programmes are humanitarian in focus and do not contribute to broader development of the health system. This in turn distorted the management hierarchy of the Ministry of Public Health, whereby programme managers become more powerful than division directors. Starting in 2004, a group of MPH staff and Congolese health advisors working in other agencies (known as the internal diaspora) began to analyse the problems found within the health sector as a whole[11]. Their main findings were:

1. **The under-financing of the health sector** due to the de facto disengagement of the State for more than fifteen years, the limited contributions of the international community and the impoverishment of the population. This has resulted in (i) the collapse of the structures providing health care, (ii) the commercialization of the health sector with many perverse effects, (iii) major barriers hindering access for a very large part of the population and (iv) the negative effects of the current financing of a commercialized system. The financial barriers and the inadequate supply would appear to offer a better explanation for the under-utilization of the services than a lack of demand.

2. **The problem of human resources,** namely an over-supply of ill-trained and underpaid personnel, constrained to seek the advantages available through externally financed

[11] A full list of health sector reviews / assessments were referred to in the HSS proposal including in Table 5.1, page 20, including the MPH's Health System Strengthening Strategy, GoDRC's Growth and Poverty Reduction Strategy, WB Report on Health and Poverty in DRC, etc

vertical programmes to the detriment of the work to be carried out within the health zone or to exploit their customers through a supply of care of sometimes dubious quality. This will necessitate a whole series of measures, such as the adjustment of inadequate remuneration, the paying off of the 5-10% of the personnel awaiting retirement, policies for the accreditation of training institutes and the reform of the civil service.

3. **The organization of the health zones** has become fragmented and no longer has any clear frame of reference. Team work on the extension of cover with all elements of basic care has given way to uncoordinated ad hoc activities within a context of vertical programmes. There is an urgent need to return to a frame of reference that specifies the modalities of operation for all of the services.

4. **The lack of leadership of the Ministry of Health.** The marginalization of the MPH in budget terms has resulted in: (i) the loss of its power to make decisions independently (ii) the manifest difficulties in coordinating the funding agencies and their sometimes misplaced initiatives, (iii) a lack of control and authority over the financing of the sector and (iv) a failure (until recently) to maintain the planning framework of the health zones in the face of a multitude of external initiatives which, though uncoordinated, enjoy the benefit of an outside financial support that bears no comparison with that of the health zones.

This analysis led to the development of a Health Sector Strengthening Strategy (HSSS) in 2006. The HSSS has six main axes:

a) Revitalisation of health zones (zones de santé) and correction of distortions found at decentralised levels.
b) Reorganisation of intermediary and central levels
c) Rationalisation of health financing
d) Reinforcement of intra- and inter-sectorial partnerships
e) Development of human resources for health
f) Reinforcement of health systems research

The HSSS particularly recognises the need to strengthen public sector management capacity across all levels of the system. The HSSS aims to impose better controls, licensing and regulation in the private sector through developing the capacities of Health Zonal, Provincial and Central health teams. The Ministry of Health has three key roles to play in improving accountability of private sector services: A normative role; a regulatory role and a coordinator

role. In its normative role the HSSS obliges the private sector (as well as public) to use competent and appropriately trained personnel, having graduated from agreed acceptable educational establishments; and through obliging public and private sector to use equipments adhering to state-approved quotas and quality controls. The regulatory role includes granting licences (certifying degrees / diplomas of personnel having studied abroad); obliging the private sector to follow appropriate registration procedures when setting up facilities; and also through granting contracting agreements for traditional healers (including salary and subsidy agreements) in accordance with DRC legislation. In terms of its role as coordinator, the state promises to coordinate all partners within the health sector.

National trends in key immunisation rates from 2005 (baseline year for the HSS proposal) and now are as follows:

Table 2 DRC immunisation rates

Indicators	2005[12]	2007[13]	2008[14]
TRADITIONAL VACCINES			
Vaccinated infants up to 2008 (report attached)/ to be vaccinated in 2008 and beyond with 3rd dose of DTP (DTC3)	72.7%		
NEW VACCINES			
Vaccinated infants up to 2008 DTC3-Heb B3		87%	83.2%
Loss rate up to 2008 for (*new vaccines)*		_	9.1%
SAFETY OF INJECTIONS			
Vaccinated pregnant women/ to be vaccinated with titanic anatoxine	66.3%[15]	68,7%	76.9%
Infants vaccinated BCG	84.2%	94%	88.6%
Infants vaccinated measles	69.7%	79%	77.1%

Trends in vaccine coverage vary greatly from province to province, and health zone to health zone. In 2008 in particular, eastern provinces saw a significant decline in vaccine coverage due to conflict in the region and large increases in the costs of fuel, both of which hampered the ability of the MPH to provide any supplies to this area. More generally, immunisation coverage has been found to be closely correlated with the quality of management and supervision provided by provincial inspection teams and zonal health teams. Based on the analysis that went into developing the

[12] GAVI HSS Proposal, citing WHO/ UNICEF Joint Reporting Form
[13] Enquête Demograraphique et de Santé RDC 2007
[14] DRC Annual Progress Report 2008 for GAVI (2009 Ministry of Public Health, Kinshasa)
[15] Two injections - GAVI HSS Proposal, citing WHO/ UNICEF Joint Reporting Form

HSSS and analysis done on why immunisation coverage differed so much across different areas, the DRC government decided to apply for GAVI HSS funding in 2006, when the HSS window was first opened to countries.

3 The GAVI HSS proposal – inputs, outputs and progress to date

This section describes the main processes and progress to date as regards GAVI HSS funding in DRC. These are further analysed in Section 4.

3.1 HSS proposal design

With the opening of the HSS window, the DRC MPH brought together the same group of people who worked on the DRC HSSS to write the proposal for GAVI HSS. This group, known as the Health Systems Strengthening Support Group (Groupe d'Appui au RSS (or GA-RSS)), is an informal group of individuals from the Ministry of Public Health Direction of Studies and Planning (Direction d'Etudes et Planification), other MPH Directorates and Congolese health managers working for WHO, UNICEF, European Commission, World Bank, SANRU (faith-based organisation) amongst others. This group saw the GAVI HSS funding as a real opportunity to support the implementation of the HSSS and so designed the proposal to match the main axes defined within the national HSS strategy. The key elements of the GAVI HSS proposal included:

1. The organization and implementation of the strategy for the revitalization and development of the health zones:

1.1. Organization at central and intermediate level directed at three target provinces (support for axis 2: *steering of the health system* and thereby axis 1: *revitalization of the health zones*)

1.2. Implementation of the revitalization of 65 health zones in the 11 provinces of the RDC (support for axis 1: *revitalization of the health zones*)

2. Human resources:

2.1. Development of a policy and a battery of measures to tackle the problem of human resources (support for axis 5 *Human Resources* and thereby axis 1 *revitalization of the health zones)*

2.2. Establishment of direct interventions for human resources in the 65 health zones (support for axis 1 *revitalization of the health zones*)

In addition, GAVI HSS funds are contributing to the implementation of **axis 6 *Strengthening research on the health systems*** in as much as the documentation and assessment of the process and the effects of the support will contribute to the improvement of knowledge and the capacities to manage change. See **Annex 5** for full list of activities being covered by GAVI HSS funding.

They also analysed a number of criteria for choosing which provinces and health zones to work with and came up with the following: a) low immunisation coverage (i.e. <65%) and b) low support from other partners.

Most stakeholders that we interviewed who had been involved in the planning process felt that the HSS proposal was well designed to meet the health systems needs identified in the national HSS strategy. They also pointed to the particular strengths of the proposal being the emphasis on supporting provincial level and key areas of work at central level. Both these levels have been relatively neglected by donors up to now, who have tended to fund only activities at health zone or below as zones are seen as more operational and closer to service delivery.

A few stakeholders indicated that while the strategic aspects of the GAVI HSS proposal were very strong, what they had not given as much attention to was how the proposal would be put into action. Because of this programme start-up has been very slow as the government has had to put a whole range of new systems and procedures in place to fit with the principles outlined in the proposal (see 3.3 below).

3.2 HSS application and approval processes

The following provides a time line of inputs for GAVI HSS proposal development and implementation.

Table 3 Timeline of GAVI HSS Application, Approval, Funding and Reporting

Activity	Who involved	Date
National HSS Strategy completed	Multi-partner group consisting of MPH departments, donor partners and NGO partners	February 2006
Development of GAVI HSS Proposal	Same as above	Aug - November 2006
Proposal validated by (Ministry of Health and Partners – 25 in total)	Multi-partner group consisting of MPH departments and donor partners	October 2006
Proposal sent to GAVI Alliance Secretariat		November 2006
Questions for clarification received		February 2007
Clarifications provided		May 2007
Proposal approved		June 2007
First year funding received		February 2008
Second year funding received		April 2008
APR 2008 sent to GAVI Secretariat	EPI Director	14 May 2009

Once the proposal had been written it was sent to all partners for review and comments. It is worth noting that private 'for profit' stakeholders were not included in this review process, for the reasons highlighted in Section 2 above. Comments were received and integrated, and a further draft was circulated for further comments. All stakeholders interviewed indicated that the process was very participative and highly iterative. By the time it came to approving the proposal through the CCIA, all CCIA members were familiar with and happy to validate and approve the HSS proposal for onward transmission to the GAVI secretariat.

The DRC submitted its proposal in November 2006, and received questions for clarification in February 2007. These questions focused primarily on how the HSS programme would be managed. One key partner in DRC (World Bank) submitted their formal comments to the MPH after the proposal had been sent to the GAVI Secretariat and so copied their comments on the proposal to the GAVI Secretariat at the same time. The World Bank comments were reflected in some of the questions for clarification and discussed at a partners' meeting in February 2007.[16]

3.3 HSS Start up measures

The first disbursement was made in February 2008 for US$ $21 525 562 to cover year 1 (2008) funding and a further US$ 20 139 390 in April 2008 to cover year 2 (2009) funding. At this point the government recognised that they needed to put in place a more solid set of procedures and systems to support the implementation and monitoring of the GAVI HSS programme. It is fair to say that the original proposal focussed on 'what' GAVI HSS funds would be used for and 'why', without going into any detail around the 'how' to operationalise GAVI HSS. The proposal in fact is explicit about the fact that the institutional arrangements for implementing the HSSS (and therefore GAVI HSS) were still to be set up. The detailed planning around 'how to' operationalise the Health Systems Strengthening Strategy came later, hence ongoing work around manuals and procedures. GAVI HSS They decided to use the opportunity provided by GAVI HSS to set up a set of systems and procedures that would be applicable to all health programme management rather than to set up yet another management unit to provide oversight of just the GAVI funds. This process has been rather long and involved, as it has required building consensus across partners and government as to what these would look like. The first set of activities included tendering for a new structure to be put in place, a Financial

[16] The focus of the World Bank's comments was on how the overall funding would be managed, indicating that the WB's preference would be for GAVI HSS funding to be managed through an existing health related PMU rather than by the MPH. There is a fair bit of disagreement with this strategy, with other partners arguing that GAVI HSS funding should be used to help set up the needed structures in the MPH to project manage.

Agent (AgeFin) and to write a Procedures Manual that would describe the roles and responsibilities of new and existing structures within the MPH for managing health sector strengthening programmes.

The manual has now been produced and does provide reasonably detailed description of the institutional set up for programme management, which will include the management of GAVI HSS. The AgeFin tendering and contracting procedures have taken far longer than expected, and the contract with the winning agency is only likely to be signed in mid-June 2009, almost a year after the tendering process began (see HSS Implementation, Section 3.5, below).

The National Steering Committee (Conseil National de Pilotage - CNP) met for the first time in February 2009. This will be the steering group for GAVI HSS and similar programmes that aim to support the MPH as a whole.

In general, one can say that the HSS programme remains in its start up phase, though some aspects have begun to be implemented. With the systems and procedures now better defined and in place it is hoped that the programme can accelerate its level of implementation from July 2009 onwards.

The fact that management and monitoring systems were not in place when the proposal was approved should have triggered the GAVI Secretariat and the IRC to consider a more phased approach to supporting HSS in DRC. The proposal is explicit that various institutional arrangements need to be set up, and concerns about management capacity were raised directly with the IRC by the World Bank. The experience from DRC should provide useful lessons for the approval and monitoring of future HSS grants to equally challenging countries.

Operational management is now needed as a matter of urgency so that day to day and more routine monitoring is possible. The Direction d'Etudes et Planification (DEP), which currently assures much of the operational management of the HSS strategy needs to delegate operational authority to the newly set up interim Cellule d'Appui a la Gestion and the GAVI HSS focal points therein, while supporting this new structure to ensure that its staff have the capacity and capability to accelerate national HSSS implementation.

3.4 Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the process and quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of DRC's established health reporting and accountability mechanisms.

The APR 2008 was the first annual report to include HSS activities. The EPI Director has overall responsibility for writing, facilitating review by the Inter-Agency Coordinating Committee (CCIA) and by the National Steering Group (CNP) before submitting the report to the GAVI Secretariat. As two new elements were added to the APR this year – HSS and civil society – the EPI Programme tried to facilitate a participatory process of APR development. First, each separate responsible group was asked to prepare their section according to the APR format. The EPI programme then held a one-day workshop to discuss each section in order to refine the whole report before finalising it. The Ministry of Public Health Direction of Studies and Planning (Direction des Etudes et Planification (DEP)), which has responsibility for GAVI HSS funding did prepare their section of the report but did not attend the workshop. As such the HSS section was inserted as it had been written. This seems a wasted opportunity on the part of the DEP as discussions with the groups making inputs to the APR could have helped to enrich thinking on HSS next steps. However, their lack of participation is likely a symptom of how overstretched the DEP is, which in turn emphasises the need to put operational management structures in place as soon as possible to relieve some of the burden on the few staff in the DEP.

3.5 HSS progress to date

The GAVI HSS indicators are taken from the national HSS strategy. As mentioned above, the programme is still very much in its start up phase, so that there has been no real progress against the indicators (in Table 5 below).

Though no progress has been made against the indicators as such, this does not mean progress is not happening. Systems and procedures have been developed and a number of these are ready to be put into practice. Recruitment and contracting of the Financial Management Agency is nearing completion and the new Management Support Unit (Cellule d'Appui à la Gestion) is also being set up. In the interim an Interim Management Support Unit (Cellule d'Appui Provisoire) is performing start-up functions of the Management Support Unit (MSU); working on the CAG procedures manual, defining the roles and responsibilities of the team within the Cellule, drafting Terms of Reference for technical assistance etc. Perhaps the most important area of progress is the development of a sense of genuine ownership by the MPH the national HSS strategy. By taking the time to develop and discuss the various

structures needed within the ministry to manage sector wide programmes the DEP and its partners have helped to foster much greater appropriation of the strategies and interventions needed for systems strengthening more generally. This perception was shared across the range of stakeholders we interviewed.

While progress has been hampered by needing to put systems in place some activities have been set in motion. The following GAVI HSS funded activities have been started and have laid a good foundation for making more rapid progress in 2009:

a) National Steering Committee and related support groups have been established;
b) HSS strategy procedures manual has been developed;
c) Interim financial management agency identified and functioning;
d) Financial management agency recruited and contract ready to be signed;
e) Health zone plans have been developed in almost all 65 GAVI HSS health zones, supported through contracts with NGOs.
f) Vehicles for provinces have been ordered
g) Tender for computer equipment has been advertised
h) Negotiations ongoing on contracts for medicines (FEDECAME) and equipment (UNICEF).
i) Interim MSU in place and supporting development of CAG procedures and systems

These plans will be aggregated at provincial and then national levels to formulate a new interim national health plan. GAVI HSS funding to the 65 health zones will be determined by the contents of the zone level plans. This planning exercise is particularly innovative in that zonal offices have had to work with health facility staff to analyse health zone wide needs and decide on priorities for the next five years. They then have had to map out each source of funding for the zone's activities, identify funding gaps and state how much of the gap GAVI HSS funds will be used to fund the gap. All stakeholders, including the NGOs helping with the planning exercise, indicated this is a significant improvement in overall planning that needs replicating across all health zones.

One significant limitation in this process, resulting from the delayed establishment of the Agefin, is that the situational assessment of all health zones that was to inform the planning process has not yet begun. To avoid delaying the planning process unduly, the intention is to use the findings from the situational assessment to refine plans as of next year. The findings from the situational assessment are not expected to be ready until the end of 2009/ early 2010.

The foundations for implementing the HSS strategy have now been laid and it is likely that

progress with activities will become swifter. That being said one area that requires much more attention is the intention to introduce performance based financing (PBF) at each level of the health system (health facility, health zones, provincial offices and central level). PBF represents 25% of the overall GAVI HSS budget for DRC. As both health facility and central level staffing numbers are grossly inflated in some areas all stakeholders acknowledge that performance based financing will be meaningless without significant reform and rationalisation of personnel.

Table 5 Progress against HSS Indicators

Indicator(s)	Indicators: baseline data and targets[17]				
	Base year	Year of GAVI application	2008 Targets	2008 Actual[18]	End Project Target
	2005	2006	2008	2008	2010
HSS inputs					
Rate of budget execution of financing allocated to the HZs	40%	56%	65%	0.5%	82%
HSS activities (3 main)					
Proportion of provinces with operational PSC	0%	0%	30%	54.5%	100%
Proportion of target health zones with a Health Development Plan	0%	0%	35.7%	2%	100%
Number of operating health zones among those targeted	No data	No data	+12	n/a	65
Outputs (impact on the capacity of the system)					
Health coverage in the health zone targeted	No data	No data	+8.7%	n/a	19%
Number of provinces with an operational basket funding system	0	0	1	0	6
Impact on immunization (DPT3 and routine measles)					
Additional percentage of children immunized with DPT3 in the target health zones	0%	0%	10%	n/a	20%
Additional percentage of children immunized for MEASLES in the target health zones	0%	0%	12%	n/a	25%
Impact on infant mortality (children under the age of 5)					
Infant / Child mortality (under the age of 5)	213 deaths per 1 000 live births	-	-	148 deaths / 1000 live births[19]	185 deaths per 1 000 live births

[17] Baseline indicators and targets taken from the GAVI HSS proposal, 2006
[18] Annual Progress Report 2008, Ministry of Public Health, Kinshasa

The particularly low rate of budget execution allocated to the Health Zones (0.5%), as well as the very small 'Proportion of health zones with a Health Development Plan' (2%) is due to the fact that the planning phase was just beginning at the end of 2008. This evaluation team found this process to be well underway as of June 2009 and more advanced than the table above suggests; reporting on progress up until the end of 2008.

3.6 End of HSS Assessment

The slow start up of the programme, and related weak progress against HSS indicators mean that a more thorough evaluation of the GAVI HSS funding will need to be done in 2011 at the notional end point of the DRC programme. However, the innovations that GAVI HSS funding has the potential to catalyse are much more around facilitating new systems, procedures and structures within the MPH that could position the ministry to take on much stronger leadership and programme management in future. These sorts of outcomes are less tangible than those expressed in the proposal and results framework, but are at least, if not more, important to monitor and review at the end of the current programme's funding. While no indicators for these intangibles are included in the GAVI HSS proposal it would be a shame to not have assessed the degree to which GAVI HSS has helped the MPH establish and use these systems and procedures.

It will also be very important to review the comparative impact of GAVI HSS support in relation to what is happening in other provinces and health zones. In particular, the programme has made an important assumption that, by supporting provincial medical inspection offices, there will be a significant effect on supervision and performance at health zone and health facility level. This assumption needs further testing and review.

Any future evaluation should focus on the processes and systems as much as on the outputs and outcome.

In light of the above, the 2011 or 2012 evaluation of HSS funding should look at:

- Comparative provincial and health zone immunisation rates, with comparisons made with non-GAVI HSS funded provinces and health zones
- Analysis of the institutional framework within the MPH and how well the CAG is functioning and is integrated within the MPH more generally.

[19] Though this data is highly questionable given the difficulty of accessing birth and death data in DRC, especially in the conflict zones in 2008.

3.7. Support systems for GAVI HSS

The support systems for GAVI HSS are being developed at a number of levels, and can best be described as nascent. No technical assistance was used by the MPH explicitly for support to the HSS programme, though existing technical advisors within the MPH, and health technical advisors working in partner agencies have played an important support function for developing and reviewing the national HSS strategy generally, and GAVI HSS in particular.

During the GAVI HSS proposal development process in particular, however, WHO provided specific support in terms of introducing GAVI HSS, hosting orientation meetings and coordinating a comprehensive peer review process. WHO AFRO organised a regional workshop in Cameroon attended by countries (Burundi, Cameroon, DRC etc) planning to submit GAVI HSS proposals. The workshops facilitated an exchange of views and peer review of one another's proposals.

Both long term and short term technical assistance were included in the GAVI proposal. The DEP has used short term TA to help with writing the procedures manual for implementation of the national HSS strategy (and within this GAVI HSS funding). The World Bank assisted in identifying the technical assistance for this work. Three long term technical assistance posts will be recruited to work with provincial medical inspection teams to help with provincial planning and to support health zones.

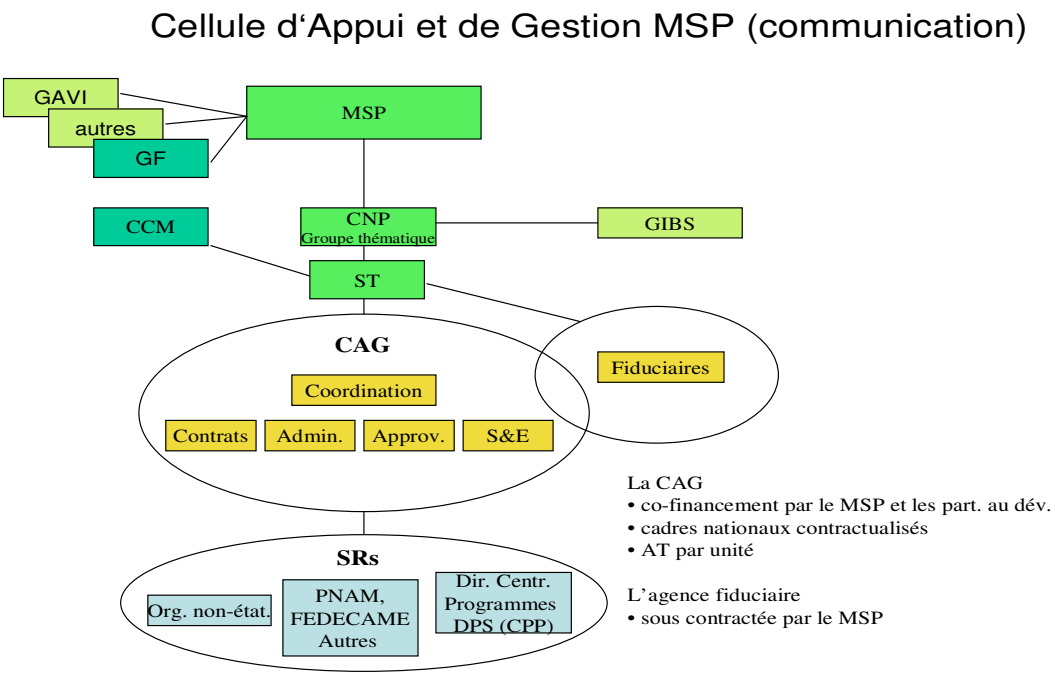
Strategic management of the GAVI HSS programme is reasonably well developed as this is the overall coordination body for the national HSS strategy, the National Steering Committee (Comité National de Pilotage – CNP). The CNP is a large partnership body and has so far only met once, in February 2009. This first meeting was used to analyse bottlenecks in HSS strategy implementation and to make decisions for how to overcome these. The CNP is supported by a Technical Secretariat (Secretariat Technique), which is in turn supported by four technical working groups (commissions) namely: planning and budgeting; financial management; contracting (including performance based financing) and medicines supply. The notable absence amongst these commissions is a commission on human resources. Given the critical importance of human resource reform for strengthening health systems overall in DRC the government and its partners need to put in place a fifth commission on human resources to help analyse what reform and how to manage it, and then monitor reform processes.

The main gap in support structures that now exists is an operational manager of the programme. At present the DEP Director, with support from his team, has been trying to assure

the day to day operations of the programme. However, this Direction is responsible for a number of different projects and has limited capacity to devote to their management. The Director has also admitted to having had to learn detailed aspects of management, particularly around contracting and procurement, that he and his department haven't had to handle before. The new Management Support Unit (Cellule d'Appui à la Gestion) is being set up to take on this operational management role and is to have two GAVI HSS focal points that will carry out programme monitoring functions and relate directly to the FMA. Figure 1 below provides an overview of the management structure for the HSS strategy, and therefore GAVI HSS, and the links between the different levels.

It is worth noting here that the MPH at present has no Directorate of Administration and Finance (DAF). The General Services Directorate used to hold many of the functions of a DAF some years ago but has been gradually stripped of most of its responsibilities – it now plays primarily a human resource management function, which focuses on trying to find posts for the very many job seekers sent to the Ministry by various politicians. The long term vision for setting up the CAG is that this will eventually become the Ministry's DAF, with the advantage that the CAG will be set up based on open recruitment so that the unit can employ the most competent people rather than be subject to political manipulation.

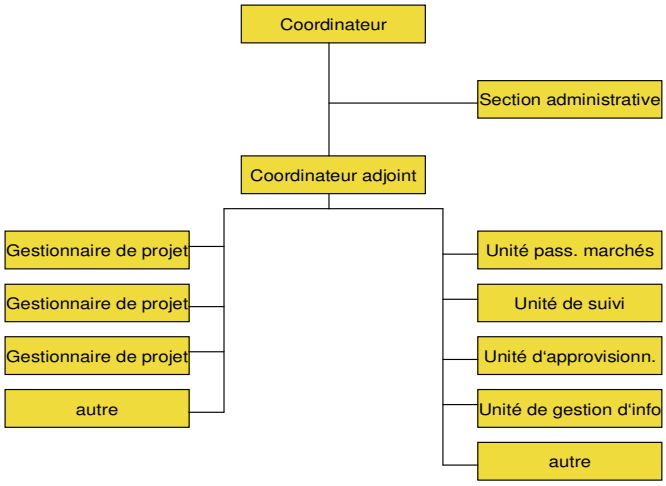
Figure 1 Lines of Communication for the CAG within the Ministry of Public Health[20]



[20] Explanatory notes: GIBS is the Health Sector Donor coordination body, 'Fiduciary' is the FMA; 'ST' is the Technical Secretariat of the National Steering Committee; 'CNP' is the National Steering Committee

The organigram of the CAG is provided here below in Figure 2:

Cellule d'Appui et de Gestion MSP (organigramme)



Now that the longer term Financial Management Agency – Agence de Financement (AgeFin) is due to begin work soon it is imperative that the operational management structures are set up as soon as possible. Otherwise the DEP risks being overwhelmed by trying to keep up with the day to day management of a very complex programme and will lose sight of the strategic role it must play in overseeing all health system strengthening activities.

3.8 Monitoring and Evaluation Framework and Support for GAVI HSS

The GAVI HSS results framework is aligned with the Health Systems Strengthening Strategy, however, only output and outcome level indicators were included in the HSS proposal. Detailed process level indicators will be drafted at health zone level and during the health zone planning process, which is currently underway. As mentioned above, the results framework may be missing some of the most critical contributions GAVI HSS funding could be making to the DRC health system. Due to nature of activities planned, these critical contributions (e.g. supporting health sector reform) are less tangible than, say increasing immunisation coverage rates, but are likely to have a more significant impact on the overall functioning of the DRC health system.

The current Manual of Management Procedures outlines the following components and characteristics in order to track progress against achieving a strengthened health system:

- GAVI HSS activities (and eventually all external funds) are to adhere to the coordinated and harmonized vision of M&E under HSSS as they will be monitored using the National Health Information System (SNIS) existing templates and procedures
- Through its Monitoring and Evaluation Unit, the Management Support Unit is tasked with ensuring overall supervision and management of monitoring and evaluation of activities for all health programmes financed internally (by the State) and externally (donors). Directors of the various Health Directorates ('*Directions*') within the Ministry have a normative role to play in supporting M&E activities and ensuring programme alignment with national policy and strategy. The NSC, Provincial Steering Committees, Zonal Conseil d'Administration (Zonal Central Bureaus) and health partners also have an important role to play in reviewing progress against the national HSDP during regular meetings / workshops and reviews.
- The routine monitoring and supervisory activities proposed for the health sector as a whole are clearly outlined in the Manual of Management Procedures of the Health Sector[21] and are in line with HMIS procedures. The roles and responsibilities of each partner, tools to be used, as well as the timing of respective monitoring and evaluation activities are also clearly outlined in the manual.
- Additional to routine HMI, data will also be collected via service providers (NGOs, donors) whose projects and programmes are eventually to be managed by the MSU and follow the MSU common procedures. In the interim, partners will be encouraged to choose indicators, a methodology and frequency of data collection that is as closely aligned to HMIS as possible. Stakeholders interviewed acknowledged that this represents a significant challenge. Aside from the pressure on partners to show results specific to their programmes, the use of common procedures and pooled funds (when new contracts begin) will not be easy to achieve given different partners' planning and budget cycles. So far the 10th European Development Fund starting 2011 has already agreed to adopt the harmonized approach.
- Ad hoc evaluations including such as theme-specific sentinel site surveys (e.g. for Malaria, HIV/AIDS, vaccination), surveys (including client-satisfaction surveys), DHS, diagnostic studies, operational research, mid-term and final programme evaluations are also planned, among which data relevant to GAVI HSS indicators will no doubt be captured.

[21] Manuel de Procédures de Gestion applicables aux Financements du Secteur de La Santé – PGFSS. This manual is a living document and stakeholders were keen to emphasize that its contents will adapt to the evolving context and needs

In sum, the Monitoring and Evaluation framework outlined for monitoring progress against the HSS Strategy appears to be well thought-out, aligned with HMIS, defines clear roles and responsibilities, monitoring tools and processes. However, effective implementation of M&E activities will take time and effort until the zonal, provincial and central teams have built up sufficient capacities within their teams. Aligning all future externally funded programmes' M&E systems will also be a challenge requiring continued dialogue and commitment amongst all partners.

4 Alignment of HSS with GAVI principles

This section will attempt to analyse the extent to which the DRC HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Equity issues – does GAVI HSS attempt to support an equitable distribution of health?

4.1 Country Driven

The development of the GAVI HSS proposal and now the implementation is very much country driven. One of the most positive aspects of GAVI HSS funding cited by almost all stakeholders was the degree to which the GAVI HSS funding has helped the DRC government to embrace its own health system strengthening strategy and therefore lead the push for restructuring within the MPH to develop the systems and structures necessary for national programme leadership and management.

The various reforms being planned will already help to improve management and communications within the Ministry. The next phase of reform that the government needs to embark on is rationalising the human resources in the Ministry, at all levels including service delivery. Any interventions that include performance based financing, such as those to be funded by GAVI HSS, will be close to meaningless unless the DRC government leads a process of reducing the numbers of staff working in central level departments as well as within health facilities.

4.2 Is GAVI HSS aligned?

4.2.1. Alignment with National Plans and Systems

The GAVI HSS proposal is completely aligned to the National Health System Strengthening Strategy and the priorities outlined therein. Perhaps more so than in other countries, GAVI HSS funding is seen as the means to operationalise this strategy at the heart of the Ministry of Public

Health. This degree of ownership and alignment is to be applauded. It has come at a cost though, as it has meant substantial delays in implementing GAVI funded interventions while the MPH took time to set up all the systems and procedures required for implementing and monitoring the national HSS strategy as a whole. The advantage that most stakeholders saw in GAVI funding is that it has been flexible and tolerant of these delays and allowed the government to work through the necessary steps to set up their own mechanisms properly.

4.2.2 Alignment with budget and reporting cycles

The DRC financial year runs from January to December. Ordinarily, the DRC budgeting process begins with preparations in March, consolidation around July, submission to parliament in August / September and finalisation in November, ready for execution in the new year by promulgation of budgetary law. To date there have been 6 Rounds of GAVI HSS applications over a period of 2.5 years – which means that so far countries have had at least two chances to apply each year. In the case of DRC, its application was submitted in November 06 during Round 1 and the MPH received confirmation of its approval in June the following year (Round 2). This means that the government was able to take into account the commitment of GAVI HSS funds for the year beginning 2008.

GAVI funds are 'on plan' but not 'on budget'. Public sector financial management systems in DRC are almost non-existent, where the Ministry of Finance has weak capacity to disperse and monitor public funds. As such, GAVI HSS allocations are deposited in a commercial bank account and two signatures (WHO representative and the DEP Director) are needed to withdraw money. The MPH hopes, with the stimulus of GAVI HSS funds, that provincial health basket funds that multiple donors will contribute to in order to increase support to and coordination and alignment of health interventions at decentralised levels.

The annual reporting process is also well aligned in theory, since the Ministry of Health Sector National Reviews are set to take place during March / April – i.e. during the same period that GAVI reports are being prepared. Therefore GAVI HSS reports should be able to rely on HMIS information documented in the MPH Annual reviews. In practice, however, and where delays occur in government reporting, GAVI HSS reports also risk being delayed.

4.3 Is GAVI HSS Harmonised?

Donor partners certainly appeared to share the vision and intention to work in harmonisation with the MPH DRC, further strengthened by a Memorandum of Understanding signed between their agencies and the National Steering Committee in 2006. In practice, however, the translation of good will and intention into reality will be a particular challenge, notably at the operational level of

the health zones where many zonal health teams are still nascent and will require time to assume ownership of their health plans and activities. It will also take time and effort for donors to adapt their own procedures and planning cycles to those common procedures proposed by the MPH. However, the EU confirmed the first positive step in this direction; having agreed to adhere to the government's common set of procedures (as defined in the GAVI HSS supported Procedures Manual) through the 10th European Development Fund, to begin in 2011.

In the meantime, there is also evidence from stakeholder interviews that partners welcome GAVI HSS' promotion of complementarity among health partners, through joint planning and budgeting carried out at the operational level of the health zones.

Another important aspect of harmonization that contributes to health outcomes concerns the integration of services at the operational level. Through improving the provision of curative services via health systems strengthening, GAVI HSS should serve to promote better integration of preventative services such as immunization.

4.4 Is GAVI HSS funding predictable?

The GAVI HSS funding disbursement in DRC has been peculiar, with two years worth of funding released within two months of each other in first four months of 2008. This funding disbursement was probably premature and the MPH say they did not ask for the second year's disbursement. As such, around US$42 million has been sitting virtually unused in one of DRC's commercial banks for over a year.

The added risk in disbursing so much funding at once is that there are concerns that the bank where the GAVI account sits may not be solvent. It is critical that the new Age-Fin analyse the safety of GAVI's funds as one of its first tasks, and if necessary, recommend that the MPH move the GAVI account to another bank as a matter of urgency.

4.5 Is GAVI HSS accountable, inclusive and collaborative?

The strategic structures that have been set up to oversee the implementation of the national HSS strategy (the CNP, the Secretariat Technique and the Commissions) are all important for assuring the accountability and inclusiveness of the GAVI HSS programme. What impressed this evaluation team was the degree of consistency across all stakeholders when they described these different structures and their roles. There is clear understanding and agreement of the functions these different structures can and should play.

It is still too early to analyse how effective these structures already are. However, there are

encouraging signs in that the 2008 APR was reviewed by the CCIA and then sent to the CNP for validation before forwarding to the GAVI Secretariat. The EPI Director mentioned herself that the CCIA should, and is likely to become, a technical working group of the CNP, thus further strengthening coordination of programmes across the Ministry.

4.6 Does GAVI HSS have a catalytic effect?

There is no doubt that GAVI HSS funding in DRC has been catalytic. Many key informants commented on this, using the term 'catalytic' to describe the impact the GAVI HSS window has had. The key catalytic effect has been to move the national HSS strategy from the realms of theory and supposition to reality through pushing the thinking on how the HSS strategy is to be managed and implemented. This effect is illustrated by the fact that GAVI HSS processes involve all main partners and actors working in the Health sector: The GIBS and all Ministry of Health Directorates participating in the design, implementation and steering of GAVI HSS. All actors share one vision and one goal. Since GAVI HSS is supporting the HSSS and the development of management and coordination capacities at central, provincial and zonal levels, it could also be considered to be contributing to the regulation of private sector partners, though this remains to be tested.

Stakeholders also commented positively that GAVI has been a pioneer; in being the first donor to allow the government to decide how to use their funds for government determined priorities, rather than imposing a donor agenda on government.

4.7 Is GAVI HSS Results Oriented

The GAVI HSS proposal for DRC has a degree of results orientation, but the results framework may be missing some of the most critical contributions GAVI HSS funding could be making to the DRC health system. Unfortunately, these critical contributions are also less tangible than, say increasing immunisation coverage rates, but are likely to have a more significant impact on the overall functioning of the DRC health system more generally. The more interesting questions to be asked when understanding what 'results' GAVI HSS have produced will be:

- To what degree has GAVI HSS funding helped to catalyse health system reform more generally in DRC and what effect have these reforms had on improving services?
- To what degree has GAVI HSS funding helped the government to tackle more politically sensitive problems, such as human resource reform within the MPH?
- Has the support provided to provincial medical inspection teams stimulated better performance in health zones and amongst health staff?
- Have HSS funds arrived successfully at the level of health zones and provinces?
- Have all partners fully adopted the principles of harmonisation and pooling of funds?

- To what extent is the HSSS being fully operationalised?

4.8 GAVI HSS sustainability issues

The DRC is likely to be highly aid dependent for many years to come, especially in the health sector. There are still too many government reforms required for the substantial resource wealth of DRC to be translated into a meaningful budget for financing all the development priorities of the country.[22] However, GAVI HSS funding does represent an opportunity to put in place the systems, procedures and capacity needed at central, provincial and zone level that will allow health programme interventions, not just immunisation, to be sustained over the longer term. As such it is contributing to programmatic sustainability.

A key challenge for GAVI, as for other donors in DRC, is ensuring the sustainability and benefit of performance based financing schemes that have been put in place. At present there is no indication that public service reforms will occur quickly enough nor that government allocations to the health sector will increase to a sufficient level, to increase the chances that PBF will have much impact or that the impact can be sustained over the longer term. It would be interesting for GAVI, along with other global HSS donors, to examine this issue more closely across a range of countries that have introduced PBF as a means of improving staff performance.

4.9 Does HSS funding help improved equity

The choice of zones and provinces, those that were least well served and had the poorest indicators, should mean that GAVI HSS support will help to bring these areas up to at least the national average if not more. This assumption will need to be tested at the end of HSS funding evaluation.

4.10 Other Issues

4.10.1 Additionality and financing of health systems strengthening efforts

For 2009 there is an estimated $94million in donor funds committed to HSS efforts. GAVI HSS' contribution within this accounts for approximately 13% ($12m). The detailed list of financial contributions of each development partner is attached in Annex 6. The World Bank (PARSS), European Union (FED9) and USAID (AXXES) are the other major financial players in terms of HSS, collectively accounting for approx 71% of these funds, with the remainder provided through AfDB, BTC, GTZ and SIDA.

[22] One indication of how far DRC has to go is the comment made by some stakeholders that, while there is at least now a national budget and funds disbursed according to this budget, the Ministry of Budgets does not have the capacity or capability to monitor whether the funds it provides to line ministries are actually spent against plans and budgets.

The majority of these funds are being used at the province and zonal levels to support the functioning of health zone and provincial teams. However around 16% of GAVI HSS funds for 2009 are targeting central level health sector coordination (National Steering Committee), financial and administrative management structures and functions (Management Costs). GAVI HSS is the only donor funding currently supporting central level health system strengthening in DRC, and the initiatives being undertaken are being watched with interest by other major donors in the country. It is particularly in this sense that GAVI HSS funding is additional and catalytic for DRC. It will remain to be seen whether GAVI HSS funding stimulates increased DRC government funding for the health sector or whether it inhibits increasing the share of the national budget allocated to the health sector. This will need further exploration once the current phase of GAVI funding comes to an end.

4.10.2. Counterfactual

More than many countries evaluated in the wider GAVI HSS review, the counterfactual in DRC is more apparent. Many stakeholders said either explicitly or implicitly that, had GAVI HSS funding not been available when it was, then the DRC health system strengthening strategy would never have a) been owned by government stakeholders as it is now; b) have had the support systems and procedures created that are necessary for the DRC-HSSS implementation and c) never have been able to initiate the reforms to the planning system that have started thanks to GAVI HSS. These are important achievements, especially when so little of the HSS funding has actually been spent yet, and need to be monitored and documented as the evolution of the HSSS and reforms progress.

Annex 1 Programme of Work and List of People met

When	Who Met	Institution
Sunday 7 June 10 am arrival 20:00	 Arrival Cindy Carlson Arrival Helen Maw	
Monday 8 June 9 am 11 am 12pm 2 pm 4 pm	 Dr. Hyppolite Kalambay Ntembwa, Director Dr. Fabienne Ladriere, Advisor Lydia Mitanta, Contracting Officer Dr. Vital Mondonge, Director Dr. Jean Pierre Noterman, Health Attache	 Direction des Etudes et Planification Cooperation Technique Belge / Direction des Etudes et Planification UNOPS Direction de lutte contre les maladies Belgian Embassy
Tuesday 9 June 10 am 12 am 1:30 pm 3pm onwards	 Dr. Albert Kalonji, Program Manager Dr. Valentin Mutombo, Deputy manager Mr Chelo, Director Document review	 Project AXxes, SANRU Rotary Club Directorate of General Services and Human Resources
Wednesday 10 June 8 am 10 am 2pm 4 pm 4 pm	 Dr. Bart Callewaert, Health Program Manager Dr. Michel Mulohwe, Health Project Manager Dr. Jacques Wangata, Coordinator Dr. Dieudonne Motema, Technical Advisor Dr. Micheline Mabiala Eleyi, Director Mr. Bonny Sumaili, Technical Adviser PEV Mr. Thierry Kazadi, Technical Adviser GAVI RSS Dr Toko, RSS Projet Manager Dr Costa, Child Survival Team Leader	 European Commission Health Sector Rehabilitation Support Project, Coordination Unit (World Bank funded) GTZ Health Program EPI Programme UNICEF
Thursday 11 June 9 am	Cindy departs am Dr. Kante Kebe, Head of GTZ IS	 GTZ IS

	Porfolio, DRC Mr Michel Descouens, Consultant	
11 am	Dr. Jean-Pierre Lokonga	Financial Management Specialist, WHO
2 pm	Sylvie Monette Dr Marie-Jeanne Bokoko Marie-Adèle Matingu Dr. Jean-Pierre Noterman, Health Attache	CIDA Cooperation Canada GIBS Belgian Embassy
4pm	Document review	
Friday 12 June 9 am	Document review & appointment setting	
11.30 am	Dr. Dr Bathé Ndjoko, Coordonnateur National Dr. Godé Kanyeba, Responsable Composante PALU Dr. Pacifique Misingi, Responsable Composante VIH/SIDA Dr. Jean Claude Kazadi, Responsable Suivi et Evaluation Ir Senez Fundi, Gestionnaire des données Dr. Audry Mulumba, Coordonnateur Adjoint Phamacist Franck Biayi, Responsable Approvisionnements	Cellule d'Appui a la Gestion (Provisoire)
1 pm	Dr. Mondo, Medecin Chef de Zone	Kokolo Military Health Zone, Lukunga District, Kinshasa Province
3 pm onward	Document review	
Saturday 13 June	Report writing Briefing Meeting	
Sunday 14 June	Report writing	
Monday 15 1pm	Prof. Kayembe	Ecole de Santé Publique Kinshasa
Tuesday 16 June 8 am	Dr. Ngilo, Director	Direction d'Etablissement des Structures de Santé
12 am	Dr. Komba Djeko, Director	Direction des Etudes et Sciences
1 pm	Dr. Kalambayi Hypolitte	Direction des Etudes et Planification
2 pm	Dr Ntona, Chairman Dr. Botuli, Chief of 2nd Bureau	Kinshasa Sanitary Provincial Division Kinshasa Sanitary Provincial Division
	Helen departs pm	

Annex 2 List of Documents reviewed

GAVI Health Systems Strengthening Proposal, DRC Ministry of Health, October 2006

APR 2008 Ministry of Health, DRC, May 2009

DRC Health Systems Strengthening Strategy, DRC Ministry of Health, June 2006 (Translation)

Minutes Of the information meeting on GAVI and the GAVI proposal procedures in connection with the strengthening of the health system, Ministry of Health Department of Studies and Planning, 15 May 2006

Minutes Of the meeting of the support group for the strengthening of the health system (GA-RSS), Ministry of Health Department of Studies and Planning, 7 Sept 2006, 8 August 2006, 29 August 2006, 13 Sept 2006

Minutes Of the meeting of National Steering Committee/ HSSS, Ministry of Health Department of Studies and Planning, 26 October (Approval of GAVI HSS proposal), 27 October 2006, 2nd November 2006 (Signing ceremony of GAVI HSS proposal)

Minutes of ICC Strategic meetings, 10 May 2007, 15 August 2007, 8 November 2007

IRC Report May 2007

Demographic Health Survey 2007 DRC, Macro International, Aug 2008

Interim Plan for Implementation of the Strategy for HSS 2007 – 2009, (Updating of the PDDS) (Master Plan for Health Development), Ministry of Health, October 2006

Medium-Term Expenditure Framework, undated

2005 Review of the DRC Health Sector, Preliminary Report, Ministry of Health, February 2006

Financial Sustainability Plan of the EPI, Ministry of Health, October 2005

Growth and Poverty Reduction Strategy, Government of DRC, July 2006

Health and Poverty in the Democratic Republic of the Congo : Analysis and Strategic Framework of the Fight against Poverty, PROVISIONAL VERSION 2, World Bank, 13 May 2005

PMPTR – Minimum Programme of the Partnership – excerpt Chapter 8: Health, undated and no author identified

STRATEGIES FOR THE REFORM OF THE HEALTH SECTOR IN THE DEMOCRATIC REPUBLIC OF CONGO

Recommendations of a support mission To the department of studies and planning Of the ministry of public health of the DRC, WHO, August 2005

Procedures Manual for the Management of Health Sector Funds, Ministry of Health Department of Studies and Planning, Draft version, May 2009

Action Plan of the Cellule d'Appui a la Gestion, CAG, June 2009

Objectifs du Millénaire pour le Développement : Rapport National de suivi de progrès pour la République, Démocratique du Congo 2004

EPI 2008 Annual Report, Expanded Programme for Immunization, Ministry of Health, Jan 2009

Comprehensive Multi-Year Immunization Programme 2008 – 2012, Ministry of Health, May 2008

Ministerial Decree for the Establishment of the National Steering Committee, Ministry of Health, 5 Sept 2006

Memorandum of Understanding (between Government and Health Partners) on the Principles of Implementation of the DRC GAVI HSS Proposal, December 2007

Terms of Reference for the Financial Management Agency (AGF), Ministry of Health, undated

Terms of Reference for the completion of the Administration and Management Procedures Manual, Ministry of Health, undated

Minutes of the first National Steering Committee Meeting, NSC for HSS, 12-13 February 2009

Contract between the interim Financial Management Agency (AGF) and the MoH, February 2009

Ministry of Public Health Activity Reports: June – July 2007, October – December 2007, January – March 2008, April - August 2008, October – December 2008, Planning and Budgetary Commission, Ministry of Health, Jan 2009

2007 Health Sector Annual Review, Ministry of Health, April 2008

Internal Evaluation of the Planning and Budgeting Working Group, Ministry of Public Health, Kinshasa, September 2008

Activity Report of the Financing Working Group, Health Secretariat, Kinshasa, September 2008

Annex 3 Summary GAVI HSS Evaluation Approach

Méthode de l'étude d'évaluation du RSS de GAVI Alliance

En février 2009, le cabinet de conseil HLSP Ltd a été chargé de l'évaluation 2009 du soutien au renforcement des systèmes de santé (RSS) de GAVI. Cette évaluation devra déterminer dans quelle mesure les opérations à l'échelon national et le soutien aux niveaux mondial et régional, ainsi que les tendances dans les systèmes de santé et la vaccination vont dans la bonne direction (positive). Des données quantitatives et qualitatives seront recueillies et analysées aussi bien de manière rétrospective que prospective, depuis le moment où le processus de demande a commencé dans le pays jusqu'à la mise en œuvre, le suivi et l'évaluation du projet à ce jour.

Il existe cinq principaux objectifs et domaines d'évaluation :

1. Quelle a été l'expérience du RSS de GAVI au niveau national en ce qui concerne *chaque* point suivant : conception, mise en œuvre, suivi, intégration (harmonisation et alignement), gestion et produits/résultats ?
2. Quels ont été les principaux points forts du RSS de GAVI au niveau national, et quels domaines précis faut-il encore perfectionner ?
3. Comment le RSS de GAVI a-t-il été soutenu aux niveaux régional et mondial – quelles sont les forces de ces processus et quels domaines requièrent des améliorations ?
4. Quelle a été la valeur ajoutée du financement du RSS de GAVI, par comparaison à d'autres modalités de financement du RSS ?
5. Quelles mesures faut-il prendre et qui devra s'en charge, aux niveaux national, régional et mondial pour préparer une évaluation plus approfondie de l'impact du RSS de GAVI en 2012 ?

L'évaluation du RSS de GAVI préparera cinq études de cas nationales détaillées. Elles seront structurées de manière que les consultants indépendants faisant équipe avec les consultants locaux passent du temps dans votre pays pour réunir des informations sur l'expérience nationale. Nous prévoyons jusqu'à deux visites dans votre pays entre mai et juin 2009. La première visite sera principalement consacrée à des entretiens avec des acteurs clés du pays pour préciser les domaines d'intérêt, à l'information et au recueil de données initiales. Au cours de cette visite, l'équipe d'évaluation chargera peut-être aussi une institution de recherche locale de mener des recherches ultérieures sur des activités/districts particuliers. Pendant la seconde visite, nous prévoyons de réaliser des entretiens avec d'autres personnes concernées, d'assembler les données et de les présenter à toutes les parties prenantes. Nous examinerons avec les acteurs nationaux l'utilité de mener un atelier de validation de fin de mission afin d'informer le pays des résultats des études de cas approfondies, et de les valider.

De plus, les résultats des études de cas approfondies seront complétées par les résultats des six études de suivi du RSS de GAVI actuellement mises en œuvre par le groupe de recherche JSI-InDevelop-IPM. Enfin, l'équipe d'évaluation du RSS étudiera tous les dossiers de demande de RSS, les propositions de RSS et les rapports de situation RSS préparés jusqu'à présent pour créer une base de données des pays bénéficiant d'un soutien RSS. Toutes ces sources d'information réunies permettront de répondre aux cinq questions de l'étude citées ci-dessus.

Annex 4 Typology of areas for HSS support.

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA ($50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	*Internal process*	IRC-HSS
IRC recommendations	*Internal process*	IRC-HSS
Decision on proposals	*Internal process*	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring

Annex 5 List of Activities being covered by GAVI HSS funding

Activity / Area of support	Cost per year (USD)					TOTAL COSTS
	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Year 3 of implementation	Year 4 of implementation	
	2006	2 007	2 008	2 009	2 010	
HSSS NATIONAL STEERING COMMITTEE						
Support for the operation of the National Steering Committee		42 400	72 400	72 400	72 400	*259 600*
Audit of the situation in the targeted Provinces and health zones		120 000	0	0	0	*120 000*
Improving the management of information						*0*
Drawing up the National Health Development Plan		80 000	0	0	0	*80 000*
Supervision of the activities of the Provincial Steering Committees		0	0	0	0	*0*
Evaluation at the half-way stage of the programme		0	0	0	0	*0*
Drawing up the country's national health map		0	0	0	0	*0*
Support for the National Health Information System in the targeted provinces		60 000	60 000	60 000	60 000	*240 000*
Support mission for the drawing up of the provincial health development plans		22 000	0	0	0	*22 000*
Monitoring implementation of the provincial health development plans		144 000	144 000	144 000	144 000	*576 000*
Research on the health systems		54 000	36 000	42 000	42 000	*174 000*
Participation in international colloquiums		96 800	54 800	54 800	54 800	*261 200*
Equipment of the National Steering Committee (NCS)		110 500	0	0	0	*110 500*
Organization of national annual reviews		75 000	75 000	75 000	75 000	*300 000*

Sub-total for NSC (1)		***804 700***	***442 200***	***448 200***	***448 200***	***2 143 300***
HSSS PROVINCIAL STEERING COMMITTEES (PSCs)						
Support for the HSSS Provincial Steering Committees		131 200	221 200	221 200	221 200	*794 800*
Organization of 56 support missions for planning in the health zones		67 200	0	0	67 200	*134 400*
Organization of a planning workshop at provincial level and/or provincial reviews		120 000	120 000	120 000	120 000	*480 000*
Supervision of the HZs by the province (4 supervision missions per annum per HZ)		40 000	40 000	40 000	40 000	*160 000*
Supervision of the HZs by the districts		80 000	80 000	80 000	80 000	*320 000*
Rehabilitation of the inspection offices		120 000	40 000	0	0	*160 000*
Rehabilitation of the regional distribution centres (RDCs)		150 000		0	0	*150 000*
Supply of essential medicines		0	3 000 000	0		*3 000 000*
Equipment of PSCs		774 500	0	0	0	*774 500*
Sub-total for PSCs (2)		***1 482 900***	***3 501 200***	***461 200***	***528 400***	***5 973 700***
DEVELOPMENT OF THE HZs						
Support for the establishment and operation of the reference general hospitals and the Health Zone Executive Teams in the targeted HZs		480 000	672 000	672 000	672 000	*2 496 000*
Drawing up Health Development Plans of the Health Zones		130 000	130 000	130 000	130 000	*520 000*
Rehabilitation / construction of health centres and reference general hospitals		1 710 000	2 010 000	1 650 000	0	*5 370 000*
Equipment of health centres and reference general hospitals		3 815 500	2 029 000	1 896 000	4 000	*7 744 500*
Working capital for the medicines of the health centres and reference general hospitals		5 250 000	280 000	280 000	280 000	*6 090 000*
Supervision of the activities of the health centres		117 000	117 000	117 000	117 000	*468 000*

Support for community activities (development of water sources)		80 000	40 000	60 000	40 000	*220 000*
Sub-total for HZD (3)		***11 582 500***	***5 278 000***	***4 805 000***	***1 243 000***	***22 908 500***
DEVELOPMENT OF HUMAN RESOURCES						
Support for the reform of Health Sciences education (Training of certified nurses)		177 120	177 120	177 120	177 120	*708 480*
Strengthening of the capacities of provincial executive teams (PETs)		84 000	56 000	56 000	56 000	*252 000*
Study trips for the PETs, including MCDs in other provinces		60 000	0	0	0	*60 000*
Training PETs, including MCDs, in planning, monitoring and evaluation		100 000	0	0	0	*100 000*
Initial training of the Executive Teams in the health zones		0	0	90 000	90 000	*180 000*
Training / retraining of nursing personnel of the health centres and reference general hospitals		45 000	45 000	45 000	45 000	*180 000*
Improving the salaries and bonuses of the health sector human resources		3 573 600	3 573 600	3 573 600	3 573 600	*14 294 400*
Training members of the zone executive teams in public health						*0*
Audit of Technical Medical Institutes		96 060	0	0	0	*96 060*
Support for the retirement of personnel in overstaffed health units		0	0	0	0	*0*
Sub-total for HRD (4)		***4 135 780***	***3 851 720***	***3 941 720***	***3 941 720***	***15 870 940***
Management costs		2 807 682	2 050 068	1 553 418	999 198	*7 410 366*
TECHNICAL SUPPORT						
Short-term technical support		24 000	6 000	12 000	12 000	*54 000*
Long-term technical support		288 000	288 000	288 000	288 000	*1 152 000*
International consulting services		400 000	300 000	400 000	200 000	*1 300 000*
Sub-total for other costs (5)		***712 000***	***594 000***	***700 000***	***500 000***	***2 506 000***
GRAND TOTAL OF COSTS		**21 525 562**	**15 717 188**	**11 909 538**	**7 660 518**	**56 812 806**

Annex 6 DRC Health Sector Financing 2009 (n.b. not exhaustive)

PROJET	BAILLEURS	Financement mobilisé (USD)	2009	Provinces /Structures bénéficiaires	Partenaires Opérationnels
PARSS	Banque Mondiale	150,000,000	37,500,000	Lutte contre le Paludisme, 8 Provinces, 64 ZS	
PA PDDS/POR	BAD	39,570,000	7,914,000	26 ZS , Province Orientale	BCECO, MOD
PS9FED (Env A)	Union Européenne	113,600,000	18,933,333	124 ZS, Nord Kivu, Province Orientale (Est), Kasaï Occid, Kassa¨Orient , niveau central	
FED (Env B)	Union Européenne		2,150,000	11 ZS , District Tanganika, Katanga	AEDES, COORDAID, COOPI, UNIVERS SUD, MALTEZER, NOVIB, FDSS, FASS
ASSNIC DEP	DGCD Royaume de Belgique	4,883,451	813,909	DEP , Minisanté	CTB
ASSNIC D4	DGCD Royaume de Belgique	8250000	1,650,000	4ème direction, Mini santé	CTB
PNTHA	DGCD Royaume de Belgique	17,407,524	3,481,505	PNTHA	CTB
ASSNIP 1&2	DGCD Royaume de Belgique	11,360,000	2,272,000	Bas Congo (2ZS), Province Orientale (3ZS)	CTB
ASSNIP 3	DGCD Royaume de Belgique	5,400,000	1,800,000	3 ZS, District de Cataractes Bas Congo	CTB
ASSNIP 4 &5	DGCD Royaume de Belgique	13,000,000	1,650,000	3 ZS, Equateur (Su Ubangi, 3SZ) & Bandundu (DS Kwilu 5ZS)	CTB
Projet d'appui au secteur santé au Sud-Kivu	DDC, Suisse	3,550,000	1,750,000	2ZS, IPS, Sud Kivu	Institut Tropical Suisse
GAVI RSS	GAVI	65,000,000	12,260,000	65 ZS , 9 IPS, Niveau Central	AGFIN, ONGs
PNSR	UNFPA	550,184			
PNSA	UNFPA	150,000			

Survie enfant	UNICEF	51,046,509	25,523,255		
Vaccination	GAVI	109,627,875	38,661,763		
AXXES	USAID	40,000,000	10,000,000	46 ZS , Sud Kivu , Nord Kivu, Maniema , Kasaï Oriental, katanga	IRCI, ECC IMA,
Renforcement du SS	GTZ	3,408,000	1,136,000		
Apui à la lutte contre la lutte contre la TBC	Fonds Mondial (R2, R3,R4,R6, R8),OMS, , CTB, ...	66,433,333	16,067,542		
Apui à la lutte contre la lutte contre Le VIH	Fonds Mondial (R3, R6, R8),OMS, , CTB, ...		172,076,908		
Apui à la lutte contre la lutte contre la Paludisme	Fonds Mondial (R3, R8,OMS, ..).		68,334,920		

TOTAL HSS	**93,965,333**
GAVI HSS as proportion of this (approx)	13%