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Prospective Country Evaluation

Democratic Republic of the Congo

2021 EXTENSION REPORT

Commissioned by the Global Fund's Technical Evaluation Reference Group (TERG)

PATH

IHME

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Table of Contents

Acronyms and Abbreviations

ACT	Artemisinin-based combination therapy
C19RM	COVID-19 Response Mechanism
CCM	Country Coordinating Mechanism
CSS	Community Systems Strengthening
CT	Country Team
DHIS2	District Health Information Software 2
HMIS	Health Management Information Systems
HRG-Equity	Human rights, gender, and equity
IHME	Institute for Health Metrics and Evaluation
KII	Key informant interviews
KP	Key populations
LFA	Local Fund Agent
M&E	Monitoring and evaluation
MoH	Ministry of Health
NFM2	New Funding Model 2 (Global Fund 2017-2019 allocation cycle)
NFM3	New Funding Model 3 (Global Fund 2020-2022 allocation cycle)
NSP	National Strategic Plan
PCE	Prospective Country Evaluation
PNAM	National drug supply pharmacy
PNDS	National Health Development Plan
PR	Principal Recipient
RSSH	Resilient and Sustainable Systems for Health
SNAME	National medical supply agency
SNIS	National Health Information System
SR	Sub-recipient
STC	Sustainability, transition, and co-financing
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
WPTMs	Work Plan Tracking Measures

1. Introduction and methods

Building from the Global Fund Prospective Country Evaluation (PCE) 2020/21 DRC country report, a three month extension phase (April-June 2021) was commissioned by the Technical Evaluation Reference Group (TERG) to focus on a deeper analysis of several areas within the grant cycle analysis. The overall objective of the grant cycle analysis was to understand what, when, why and how grant investments change over time, including significant factors that influenced the implementation of and changes to the original grant. The extension phase timing in 2021 allowed for additional analyses of New Funding Model 3 (NFM3, Global Fund 2020-2022 allocation cycle) awarded grants, which had not been available for the prior report. Key areas explored during the extension phase included:

- The understanding and use at the country level by the country coordinating mechanism (CCM), government and stakeholders of the terms health systems support and health systems strengthening.
- Reasons for the limited uptake of Resilient and Sustainable Systems for Health (RSSH) coverage indicators in the NFM3 grant performance frameworks;
- NFM3 grant making, including drivers of budgetary shifts for RSSH and equity-related investments; and
- New Funding Model 2 (NFM2, Global Fund 2017-2019 allocation cycle) grant revision issues and any relevant lessons learnt from the Global Fund's response to COVID-19.

The findings from the extension phase complement the 2020/21 annual country report findings related to grant design and implementation considerations; therefore, recommendations have been revised and updated.(1)

Data collection

During the extension phase, additional primary data were collected through document review, key informant interviews (KIIs), and meeting observations in order to more deeply examine the questions, as well as fact-checking interviews to fill any gaps in the analysis (Table 1). Budgetary analyses were updated to include NFM3 grant award budgets, which enabled analysis of module and intervention-level shifts during grant making.

Table 1. Prospective Country Evaluation (PCE) Extension phase data sources

Data Source	N	Description of data source
Document review	15	• Global Fund policy and guidance documents for the funding application process (e.g., info notes for HIV, TB, malaria, COVID-19, sustainability, transition, and co-financing (STC), RSSH, Operational Policy Manual) and COVID-19 operational procedures • RSSH funding request and related documents • COVID-19 Response Mechanism (C19RM) funding request • Newspaper articles • Meeting minutes

Data Source	N	Description of data source
Key informant interviews (KII) (7) Fact-checking / validating interviews (5)	12	**National level:** Country Coordinating Mechanism (CCM) representatives, Ministry of Health (MoH) and Civil Society Principal Recipients (PRs), Sub-recipients (SRs), Local Fund Agent (LFA) **Global level:** Global Fund Country Team
Meeting observations	2	Bi-annual review of the Global Fund (April 2021)
Approved NFM3 grant budgets	6	Final grant budgets were uploaded to Tableau for analysis and coded according to the 2S framework

It should come as no surprise that the COVID-19 pandemic was a constant concern in the DRC during the extension period. As a result, stakeholder availability was limited. The DRC PCE was able to conduct virtual KIIs, although obtaining a remote connection was technologically challenging for some stakeholders.

2. Findings

2.1 NFM2 Grant Cycle - grant revisions

2.1.1 NFM2 revision processes

Grant revision processes were viewed as administratively burdensome and complex due to the lengthy review process which often requires multiple levels of review and sign-off.

In the 2020/2021 DRC annual report, we found that frequent budget revisions took place but there were generally fewer revisions of program scope and/or scale (i.e., material program revisions). Evidence from the extension phase confirms that grant revisions continue to be viewed as administratively burdensome and complex. Factors that make grant revisions long and cumbersome are:

- Review and validation by the fiduciary agent required for MoH PRs
- Multiple stages of review and back-and-forth between the Country Team (CT) and PRs
- Country is under additional safeguard measures

Another challenge is that there is no clearly established timeline for the review process and for that reason, back-and-forth exchanges between the CT and PRs can continue indefinitely. As demonstrated in the quote below, one key informant compared grant revisions to the funding request process, noting that during the funding request review and response stages there are set deadlines for review and response which helps move the process forward.

"*In the funding request/grant-making process, the [Technical Review Panel] TRP comments and gives a country a deadline for responses. When the country responds, the TRP makes its decision within a set period of time and finalizes the process. This should also be done for grant revisions.*" - Quote from key informant

For budget revisions specifically, there are quarterly reviews and discussions between the national programs and PRs to identify budget savings, followed by submission for CCM approval. However, stakeholders reported that this process may have to be restarted if the Global Fund does not accept the proposed revisions. They also reported difficulty keeping up with the frequent budget changes.

2.1.2 Introduction of NFM2 grants flexibilities in response to COVID-19

The DRC was authorized to rapidly use NFM2 grant funds for COVID-19 response, however this was done outside of the formal grant revision process.

During NFM2, the Global Fund introduced a range of 'flexibilities' to improve responsiveness to the COVID-19 pandemic. For grant revisions, these flexibilities included lightening requirements to improve the speed and efficiency of revision processes. While most PCE countries underwent grant revisions to use NFM2 grant savings and reprogramming for COVID-19, DRC did not go through the formal grant revision process because grants were close to 100% absorption and therefore did not have resources available to reprogram. Instead, the DRC obtained Global Fund authorization to loan NFM2 grant funds to finance COVID-19 response activities, which were later reimbursed with funds approved through the C19RM funding mechanism. This occurred in unique ways that did not utilize existing grant funds and was outside of the formal grant revision process. Therefore it was not a useful comparison for drawing lessons learned on how to improve specific aspects of the grant revision process. The key lesson learned from the DRC was that the Global Fund business model demonstrated flexibility by not requiring a one-size-fits-all approach, which was most appropriate for the context and facilitated a swift response to emergency needs.

2.2 NFM3 Grant Cycle - RSSH investments

2.2.1 Strengthening vs. support

RSSH investments in DRC continue to include more health systems 'support' than 'strengthening.' Although these terms are understood by stakeholders, they did not influence the choice of RSSH interventions for NFM3, which are perceived as well-aligned with country priorities.

The updated 2S analysis of NFM3 final grant award budgets shows that RSSH investments continue to be largely providing support to health systems rather than strengthening (Figure 1). The 2S framework had been presented during the NFM3 funding cycle launch orientation workshop, including mention of the Technical Review Panel (TRP) Lessons Learned report recommendation to move beyond supporting health systems to strengthening health systems. While the terms 'strengthening' and 'supporting' are generally understood by stakeholders, the 2S framework did not seem to influence the choice of RSSH activities for NFM3. Key informants indicated that the RSSH funding request prioritized investments aimed at supporting disease-specific goals and that the emphasis on 'support' was necessary for strengthening investments to be effective. Other factors that influenced the choice of RSSH interventions were considerations of the mutual impacts and cost-effectiveness of the interventions, and their expected impact within a short, three-year grant cycle.

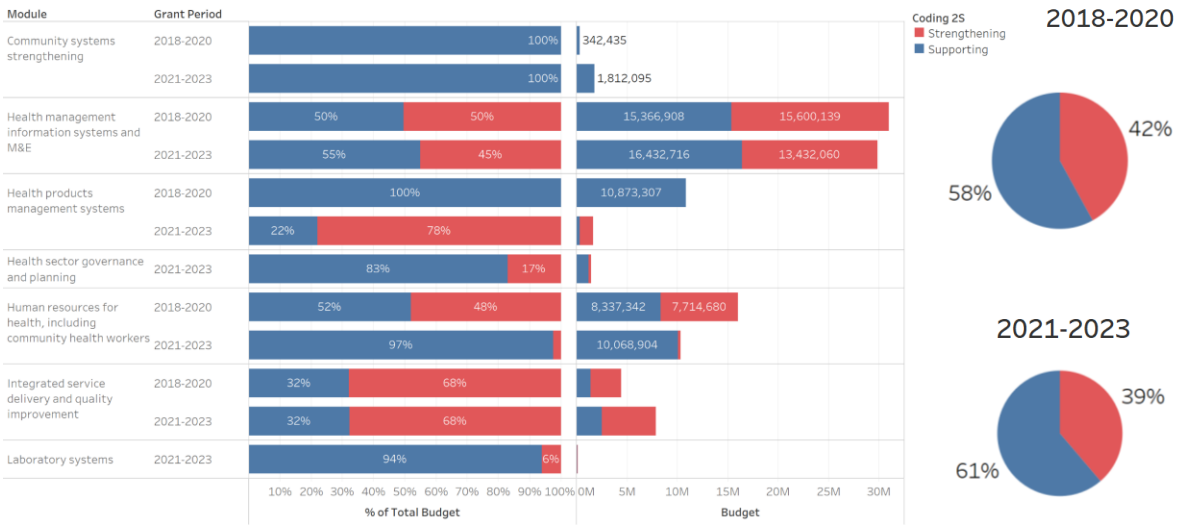
Global Fund investments in RSSH were considered by stakeholders to be aligned with country priorities. The investments are broadly addressing objective areas outlined in the 2019-2022 National Health Development Plan (PNDS); (I) Improving health services delivery and continuity of care, (ii) Supporting health system pillars, and (iii) Strengthening governance and the health system. However,

since there is not a centralized national strategic plan for RSSH, the consultants and RSSH working groups that developed the NFM3 RSSH funding request relied on the national strategy documents for specific focus areas, such as: the human resources plan, community health plan, national essential medicine supply plan, national health information system (SNIS) strategic plan, etc. Each of these documents exist as separate stand-alone strategies, however. The fact that there is no comprehensive and coordinated analysis of national RSSH financial gaps and priorities to guide RSSH investments could pose a barrier to more strategic investment in health system strengthening. The absence of such an analysis also explains why Global Fund tools, such as the programmatic gaps tables and the funding landscape table, were not used for planning NFM3 RSSH investments. The tools are formatted to draw directly from the National Strategic Plans (NSPs) and therefore were only completed for the three diseases.

When pressed on how Global Fund interventions could achieve more in the way of health systems strengthening, key informants expressed the view that support activities are essential prerequisites, without which programs could not be implemented, and therefore are a necessary complement to any investments in health system strengthening. According to key informants, they are further justified by the government's lack of sufficient financial resources to fund the support activities. However, given multiple donor investments in RSSH, other factors affect accountability, such as weak central government leadership and governance within the health sector, thus contributing to continued weakness of the health system.

"...when we don't have the minimal elements of support, strengthening the health system will not be effective." - Quote from a key informant

Figure 1. RSSH support versus strengthening "2S" analysis comparing NFM2 to NFM3 investments by RSSH module (updated with approved NFM3 grant budgets)



Despite large investments in support activities, stakeholders cited ways in which the Global Fund is indirectly reinforcing the health system by pursuing strategies that are more aligned with country systems and encouraging greater integration across disease areas.

According to key informants, Global Fund investments have grown over time to be more aligned with

country systems, as compared to previous funding that was highly vertical and less integrated. These include:

- Supporting the roll-out of the District Health Information Software 2 (DHIS2), and in the process discontinuing funding for parallel data collection systems, and requiring during NFM2 that all grant performance indicators are reported from DHIS2.
- Encouraging integration across disease areas by supporting coordinated quantification of commodity requirements, led by the national drug supply pharmacy (PNAM).
- Gradually transferring responsibility for supply chain activities over to the national medical supply agency (SNAME), including health commodity storage, warehousing, and transportation, previously managed by civil society PRs.
- Improving community health facility supervision through horizontal and vertical integration and direct funding to health establishments.
- Directly supporting provincial operational plans, such as through the provincial approach pilot project in Kinshasa and Maniema provinces.
- Directly supporting national programs.

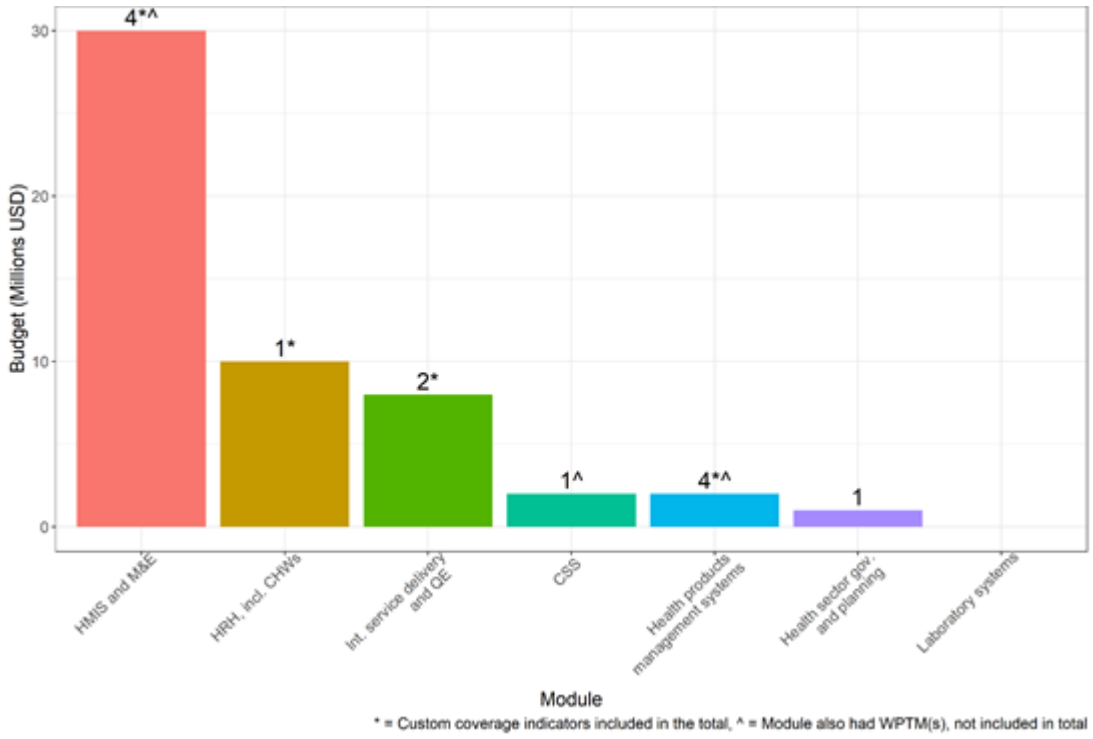
2.2.2 RSSH indicators in NFM3 grants

The total number of RSSH indicators increased from three in NFM2 to 13 in NFM3, including the addition of six custom indicators, which will lead to greater accountability and monitoring of RSSH investments during NFM3.

While in most PCE countries NFM3 grant performance frameworks did not include many new RSSH indicators, DRC is an exception. The total number of RSSH indicators increased from three in NFM2 to 13 in NFM3, including the addition of six custom indicators and multiple Work Plan Tracking Measures (WPTMs). As shown in Figure 2, six out of seven RSSH modules budgeted in NFM3 grants have associated RSSH coverage indicators. Only the module for strengthening laboratory systems, which had the lowest investment of the RSSH modules, lacked any associated indicators.

Stakeholders referenced the Modular Framework Handbook and chose RSSH indicators based on the program objectives highlighted in the national strategic plans and country priorities.(2) For each RSSH module, stakeholders chose a set of relevant indicators to follow the progress of activities in order to ensure consistent and harmonious reporting. Although the PCE has limited evidence of the factors that facilitated the increase in RSSH indicators between NFM2 and NFM3, the transition to a stand-alone RSSH grant in NFM3 was likely an important factor. For example, the TERG Thematic Review on RSSH found that embedding RSSH investments within disease grants contributed to the investments being more disease-focused rather than crosscutting and that the disease programs may not be the best placed to implement broader health systems strengthening interventions.(3) The added emphasis on RSSH performance measurement and centralized management of the NFM3 RSSH grant under the MoH should lead to greater accountability for RSSH performance. Some key informants also anticipate that these shifts will promote better absorption of RSSH budgets.

Figure 2. RSSH indicators and allocations by module, comparing funding request to approved budgets/PFs



2.3 NFM3 Grant Cycle - grant making

Various changes in the RSSH and human rights, gender, and equity (HRG-Equity) budgets were made during grant making and could not be explained by stakeholders interviewed; the lack of documentation explaining these changes and the rationales for them undermines the transparency of the grant making process.

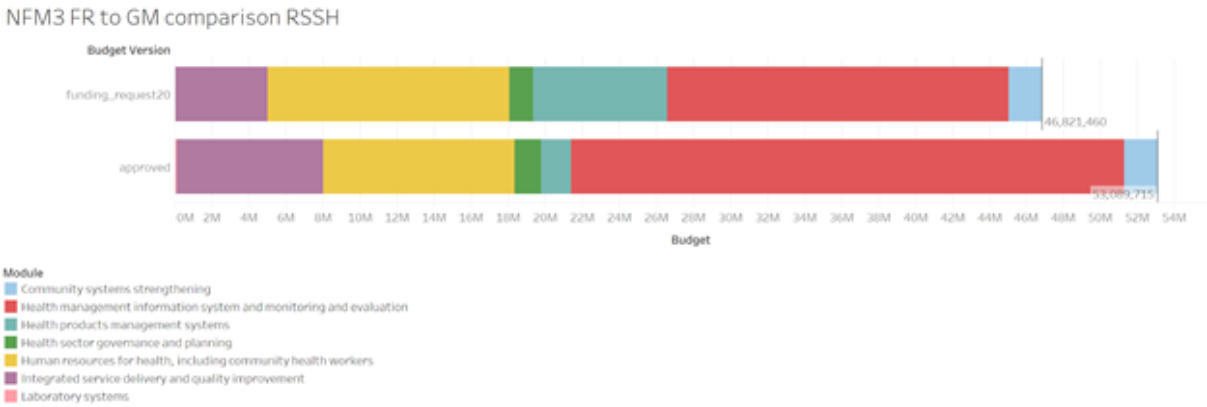
Despite greater inclusion, transparency, and country ownership during the development of the NFM3 funding request, we found that key decisions made during the grant making phase are not well-documented, nor shared with stakeholders who were not included in the process. Compared to the funding request development phase, participation in grant making is limited and reserved to specific categories of stakeholders, including the national programs, PRs, CCM, and some civil society members. Key informants highlighted the fact that there is no clear process for grant making that guarantees transparency and inclusivity. Similar to the PCE findings from the NFM2 grant making phase, the PCE found that budget and program changes from NFM3 grant making were not systematically documented, nor communicated with all stakeholders. As discussed below, many of the budget changes were not well understood by stakeholders.

DRC initially submitted a funding request with malaria and RSSH components combined, although the TRP recommended that the funding request go to iteration which resulted in the DRC stakeholders deciding to split the malaria and RSSH components into separate stand-alone funding requests. We found a 13% increase in funds allocated to RSSH between the resubmitted, stand-alone, RSSH funding

request and grant award budget (from USD $46.8 million to $53.1 million).[1] As shown in Figure 3 below, the greatest relative increase (62%) was noted in the "Health Management Information Systems (HMIS) and Monitoring and Evaluation (M&E)" module. This was due to various factors including the addition of administrative and financial data sources to facilitate collection of data on government co-financing. Other factors included the reclassification of activities within appropriate budgetary interventions, changes in activity scale (for example, increasing the frequency of data validation meetings at the provincial level), and adjustments of unit costs based on updated cost data.

While most RSSH modules increased or remained similar to prior investments, there was a large reduction in the "Health products management systems" module (from USD $7.2 million to $1.6 million). The reasons given for this reduction were related to reductions in the calculated cost of conducting activities and to remove duplication since some of the costs had already been accounted for in the HMIS and M&E module.

Figure 3. RSSH funds by module in DRC NFM3 funding requests and approved budgets



The HRG-equity budget decreased by 7.5% between funding request and grant making with many shifts between module and intervention categories. As shown in Figure 4, there were significant variations between modules and intervention categories with some module budgets increasing while others decreased. The most significant change was to the "reduction of human rights and gender-based barriers to tuberculosis services" module which increased by 126% (from USD $327,000 to $740,000) and the "reduction of human rights-related barriers to tuberculosis and HIV services", which increased by 61% (from USD $2.6 million to $4.2 million). The most significant decrease was observed in the "treatment, care and support" module which dropped by 55% (from USD $4 million to $1.8 million). The "Prevention" module had the largest allocation and decreased by 18% (from USD $18 million to $14.7 million).

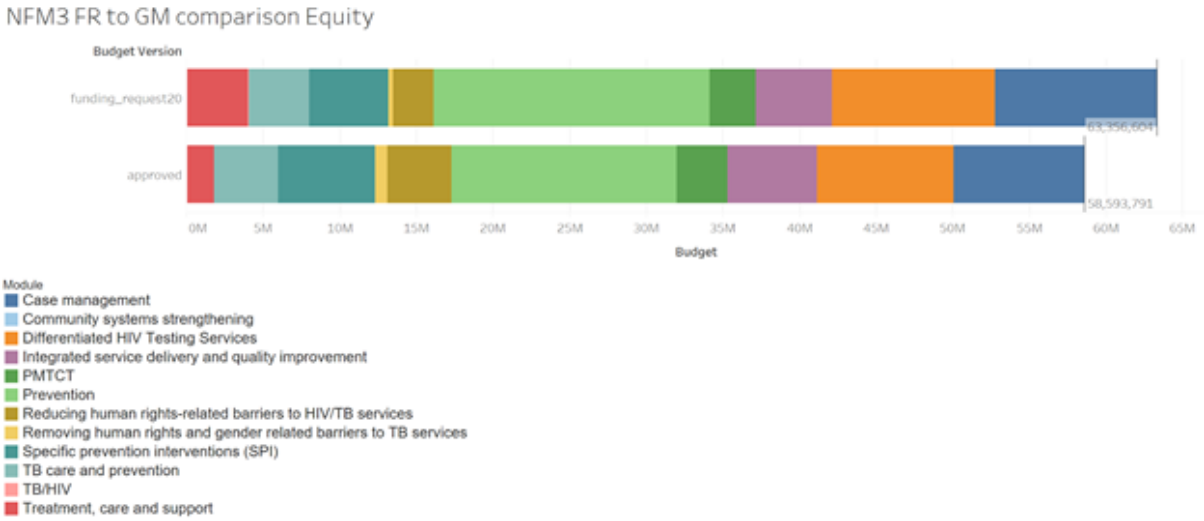
We have limited evidence to explain why specific shifts occurred at both the module and intervention levels. As we found previously during the grant making phase for NFM2, sub-recipients again reported being unaware as to why budget cuts were made to activities they are responsible for implementing. For example, one of the civil society SRs expressed concern that the HIV testing budget for key

[1] The stand-alone RSSH funding request budget was $53.3 million, however our calculation of the funds allocated to RSSH in the funding request budgets only includes RSSH modules (i.e., $38.3 million in the RSSH funding request and $8.5 million in the TB/HIV funding request). Program management costs are not included in our calculation of funds allocated to RSSH.

populations (KPs) was reduced but the rationale was never clearly explained and the SR was not present during grant making negotiations. Similar to the RSSH budget shifts, the budgetary shifts in the HRG-equity related interventions were not documented in the Grant Making Final Review Form, nor in any other document. During interviews with key informants, a variety of general reasons were provided to explain these changes, including:

- A reduction in program activities in line with the available budget.
- A decrease during grant negotiations in activities and targets to compensate for the budgetary demands of the supply chain and human resources, as reflected in the increased program management budget (although they remain much more ambitious compared to NFM2).
- The prioritization of the most essential activities for reaching the 90-90-90 testing and treatment objectives.

Figure 4. HRG-Equity funds by module in DRC NFM3 funding requests and the approved budgets



3. Conclusions and recommendations

Section	Conclusions	Recommendations
NFM2 Grant Cycle – grant revisions	1. Grant revision processes are viewed as administratively burdensome and complex due to the lengthy review process which often requires multiple levels of review and sign-off. 2. DRC was authorized to rapidly use NFM2 grant funds for COVID-19 response, however this was done outside of the formal grant revision process.	1. The Global Fund should identify opportunities for transferring greater review and approval authority for grant revisions to the CCM, empowering national stakeholders and improving efficiency. This will facilitate the eventual transfer of all processes at the country level to be managed by the CCM.
NFM3 Grant Cycle – RSSH investments	1. RSSH investments in DRC continue to include more health systems 'support' than 'strengthening.' Although these terms are understood by stakeholders, they did not influence the choice of RSSH interventions for NFM3, which are perceived as well-aligned with country priorities. 2. Despite large investments in support activities, stakeholders cited ways in which the Global Fund is indirectly reinforcing the health system by pursuing strategies that are more aligned with country systems and encouraging greater integration across disease areas. 3. The total number of RSSH indicators increased from 3 in NFM2 to 13 in NFM3, including the addition of 6 custom indicators, which will lead to greater accountability and monitoring of RSSH investments.	1. Global Fund should support the DRC in development of a consolidated national strategy for RSSH, similar to how it invests in the development of disease specific NSPs, to facilitate stronger identification and prioritization of RSSH interventions and more strategic investment in health systems strengthening.

Section	Conclusions	Recommendations
NFM3 Grant Cycle – grant making	1. Various changes in the RSSH and HRG-Equity budgets were made during grant making and could not be explained by stakeholders interviewed; the lack of documentation explaining these changes and their rationale undermines the transparency of the grant making process.	1. The Global Fund should improve transparency of grant making by: (1) providing clear communication through the CCM on the grant making process, including which stakeholders are supposed to participate and (2) ensuring that budgetary and programmatic changes, and their rationale, are well-documented by the CCM and shared with all stakeholders.

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ANNEX 1. RSSH indicators by module, comparing NFM2 to NFM3

RSSH Module	RSSH coverage indicators	NFM2	NFM3
HMIS and M&E	M&E-2a Completeness of facility reporting: Percentage of expected facility monthly reports (for reporting period) that are actually received	X	X
	M&E-2b: Timeliness of facility reporting: Percentage of submitted facility monthly reports (for reporting period) that are received on time per the national guidelines		X
	Custom: Completeness of facility reporting on logistics: Percentage of expected monthly reports (for reporting period) on logistical information that are actually received		X
	Custom: Timeliness of facility reporting on logistics: Percentage of submitted monthly logistics reports that are received 20 days following the reporting period		X
Human resources for health	Custom: Percentage of health agents that receive their salary top-up on time (within 30 days) against the number expected		X
Health products management system	PSM-3: Percentage of health facilities providing diagnostic services with tracer items available on the day of the visit or day of reporting	X	X
	PSM-4: Percentage of health facilities with tracer medicines for the three diseases available on the day of the visit or day of reporting	X	X
	Custom: Percentage of “green leaf” ACTs that were sold among the total of ACTs (all types) available in the private sector		X
	Custom: Percentage of health facilities with tracer medicines for TB available on the day of the visit or day of reporting		X
Integrated service delivery	SD-5: Percentage of facilities that receive supportive supervision – at least once per quarter		X
	Custom: Percentage of supervision pools that carried out quality supervision (according to standards and guidelines) during the year		X
Community systems strengthening	CSS-1: Percentage of community based monitoring reports presented to relevant oversight mechanisms		X
Health sector governance and planning	HSG-1: Percent of district health management teams or other administrative units that have developed a monitoring plan, including annual work objectives and performance measures		X