



The Single Contract in the Health Sector in the Democratic Republic of Congo

Knowledge and Learning Case Study

November
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TABLE OF CONTENTS

1 CASE STUDY INTRODUCTION

2 CONTEXT: CONTEXT AND ORGANIZATION

3 WHAT IS THE SINGLE CONTRACT?

4 HOW DID THE SINGLE CONTRACT TAKE SHAPE?

5 LESSONS LEARNED FROM IMPLEMENTATION

6 STAKEHOLDER REFLECTIONS

7 ANNEX: ANALYTICAL FRAMEWORK



1

Democratic Republic of Congo: Single Contract

Case Study Introduction

Case Study Introduction

Objective

The purpose of this Knowledge and Learning Case Study is to document and share the single contract experience of the Democratic Republic of Congo's (DRC) to inform operational efforts in the DRC as well as potential replication efforts in new provinces in the DRC and/or in other countries.

We hope that this work will enable you to:

- **Gain insight** into the DRC's actual experience with the single contract.
- **Identify challenges** or obstacles that you may face while undertaking a similar process.
- **Consider new ideas** and perspectives.
- **Develop skills** around a specific technical area.
- **Encourage discussions** within your national team and/or with other stakeholders.

Scope

This Knowledge and Learning Case Study focuses on documenting the factors that facilitated or inhibited the introduction, adoption, implementation and monitoring of the single contract at **provincial level** in the DRC. It highlights lessons learned and challenges faced, as well as the corrective measures taken to address them.

Case Study Introduction

Methodology used

This Knowledge and Learning Case Study adopts a qualitative approach, using Cognitive Task Analysis (CTA) to capture experiential and tacit knowledge to understand the challenges faced and the cognitive skills required to complete complex tasks. CTA provides insight into the nature of the tasks performed, as well as the means by which cognitive skills such as judgment, decision making, and the search for meaning can become drivers of performance.

This qualitative approach also draws on a literature review as well as on discussions with World Bank technical teams to identify key themes as well as key informants – whilst avoiding duplication.

Key informant profile

Key informants were selected to represent the voices and perspectives of stakeholders involved in the single contract at different administrative levels. Sixteen individual interviews were conducted with representatives from the central government, including the Directorate for Studies and Planning of the Ministry of Public Health, Hygiene and Prevention; bilateral and multilateral technical and financial partners; and cadres from provincial health divisions and chief medical officers in health zones.

Literature Review

Literature review

This knowledge and learning case study draws on published and unpublished literature on the single contract to build on existing work and ensure complementarity. Reviewed documents include the :

- Evaluation of the Implementation of the Single Contract at the Intermediate Level of the Health System in Democratic Republic of Congo (World Bank & Department of Studies and Planning, 2021).
- Article entitled "The Single Contract: An Innovative Approach to Financing the Intermediate Level of the Health Care System in the Democratic Republic of Congo: Implementation Process and Challenges." (African Journal of Primary Health Care and Family Medicine, 2021).
- Article entitled "The Implementation Process of the Single Contract Approach in the Democratic Republic of Congo." (Evidence-based Strengthening of health System Policies, 2017).
- Health System Strengthening Strategy of the Democratic Republic of Congo (Ministry of Public Health, Hygiene and Prevention, 2006 & 2010).

Technical notes, training modules, operational mission reports, and evaluation reports from the Ministry of Public Health, Hygiene and Prevention, the World Bank and Provincial Health Divisions also feature among reviewed material.



2

Democratic Republic of Congo: Single Contract
Health: Context and Organization

Health context

The Democratic Republic of Congo (DRC) has made significant progress in maternal, neonatal, child and adolescent health and nutrition. Some indicators are nevertheless still lagging. Notably, the maternal mortality rate and chronic malnutrition remain high, with respectively 846 deaths per 100 000 live births and nearly 43% of children being malnourished [1]. The country's progress towards universal health coverage is hampered by several challenges, including health financing challenges.

In 2018, 44% of total health expenditures were covered by households and 35% were funded by external financiers [2]. This overseas development assistance for health is fragmented in nature and represents an important source of inefficiency. For instance, an assessment carried out by the World Health Organization in 2015 indicated that several partners were financing similar activities at the same time in the same geographical area, signaling a lack of concerted efforts.

Despite an increase from 6.9% to 11.4% between 2016 and 2021, the share of the national budget allocated to health remains low and predominantly focused on recurrent costs, especially salaries.

The budget execution rate is modest: in 2019, only 57% of the health budget had been spent [4] and only US\$3 million were spent on maternal and child health [5].

Provinces remain underfunded in the health sector, only receiving three percent of government funding as opposed to the 10% target included in the National Health Development Program (2016-2020). This situation could hamper the ability of provincial health divisions to support and supervise the delivery of quality health services at health zone level.

Cognizant of these challenges and steadfast in its commitment to universal health coverage, the Ministry of Public Health, Hygiene and Prevention and its technical and financial partners are engaged in optimizing the allocation and use of existing resources to meet the country's health and nutrition priorities. This commitment extends to enhancing health financing at the intermediate level through the single contract.

The way through which the single contract can help promote aid effectiveness in the health sector is particularly relevant in today's context, as the 2016-2020 National Health Development Plan is being evaluated and a new health sector strategy is being prepared.

Health Pyramid of the Democratic Republic of Congo

Roles and responsibilities of in-country stakeholders

The health system in the DRC has three levels:

National level

The Ministry of Public Health, Hygiene and Prevention (MSP-HP) heads DRC's health pyramid. Lead by the Minister of Health, it includes the Secretary General for Health, central directorates, specialized programs, the General Health Inspectorate, tertiary level hospitals and other institutions operating at national/central level. The MSP-HP has a regulatory function: it defines policies, strategies, standards and guidelines; provides advisory support ; monitors compliance; and follows up on implementation at provincial level. It also plays a critical role in resource mobilisation and allocation.

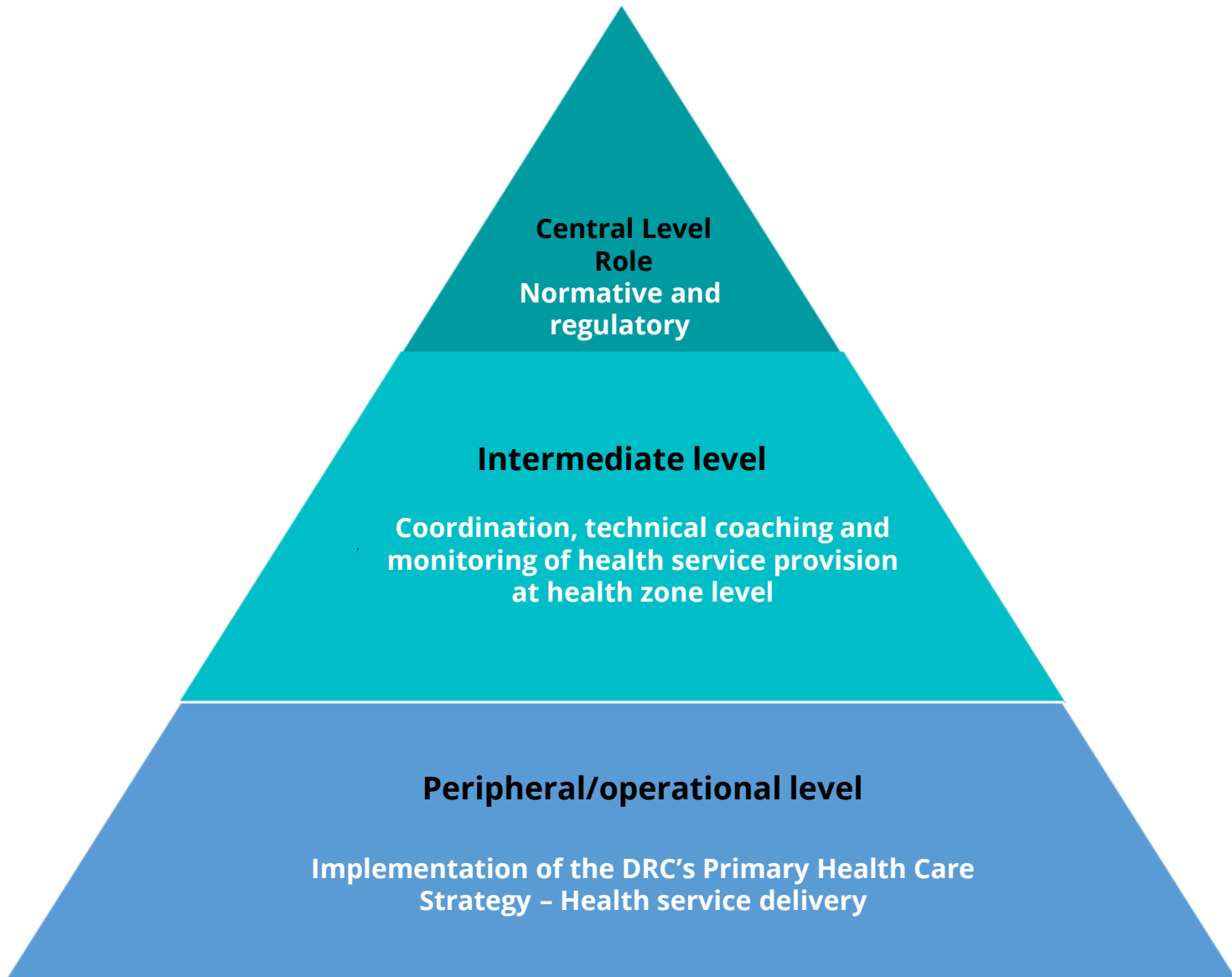
Provincial level

The provincial level is led by the Provincial Minister of Health and comprises a Provincial Health Division, a Provincial Health Inspectorate, a Regional Drug Distribution Centre, a provincial hospital and other provincial institutions operating in the health sector. It constitutes the main technical lever of the health system with regard to the regulation and provision of health services at the health zone level. It is also responsible for the inspection and control of health care facilities, health science and pharmaceutical products.

Operational level / health zones

The operational level is lead by health zones, which are responsible for the delivery of quality primary health care services. Each health zone includes a general hospital ; and each health zone is subdivided in health areas which each have a health centre. Communities are engaged in the management of health centres, notably through health development committees and health management board.

Health Pyramid of the Democratic Republic of Congo





3

Democratic Republic of Congo: Single Contract

What is the Single Contract?

A SINGLE APPROACH

Alignment to better meet health priorities

What is the single contract?

The single contract is a management mechanism developed by the MSP-HP and its technical and financial partners (TFP) to foster better coordination in terms of financing, optimize the use of available financing and better respond to health priorities at the level of Provincial Health Divisions (PHDs).

The single contract pools funding from national and external sources to cover the operational costs of provincial health divisions (PHDs). Resource allocation is based on a single operational plan, a single budget and a common performance framework. The single contract entails the active and coordinated involvement of key central and provincial stakeholders throughout its life-cycle.

The single contract aligns with the Paris Declaration and the Kinshasa Agenda for the harmonization of intervention plans and the alignment of financing with national priorities. These principles are also outlined in DRC's National Health Development Plan and DRC's Government Action Plan.

“

“The purpose of the single contract is to pool and rationally manage resources within the Provincial Health Division. This entity is responsible for coordinating, coaching and providing technical assistance at health zone level to improve the quality of health care services and enhance the health status of peoples in the province.”

- Technical and financial partner, North Kivu [6]

”

Alignment to better address health priorities

Key components

A single integrated contract

Contracts available in a province are consolidated and harmonized into a single integrated contract, which links TFPs at provincial level, the Provincial Ministry of Public Health, and the PHD. In November 2022, 14 single contracts were operational in the DRC in the provinces of Bas-Uele, Haut-Katanga, Haut-Lomami, Haut-Uele, Kongo-Central, Kwango, Kwilu, Lualaba, Mai-Ndombe, Maniema, Nord-Kivu, Sud-Kivu, Sud-Ubangi et Tshopo.

Single structural financing

The single contract takes the form of structural funding that combines financing from TFPs, the central government and from PHDs based on a consolidated provincial operational action plan and a single budget. This structural funding is complemented by incentives which are adjusted based on performance, following a logic of progressive improvement at institutional level.

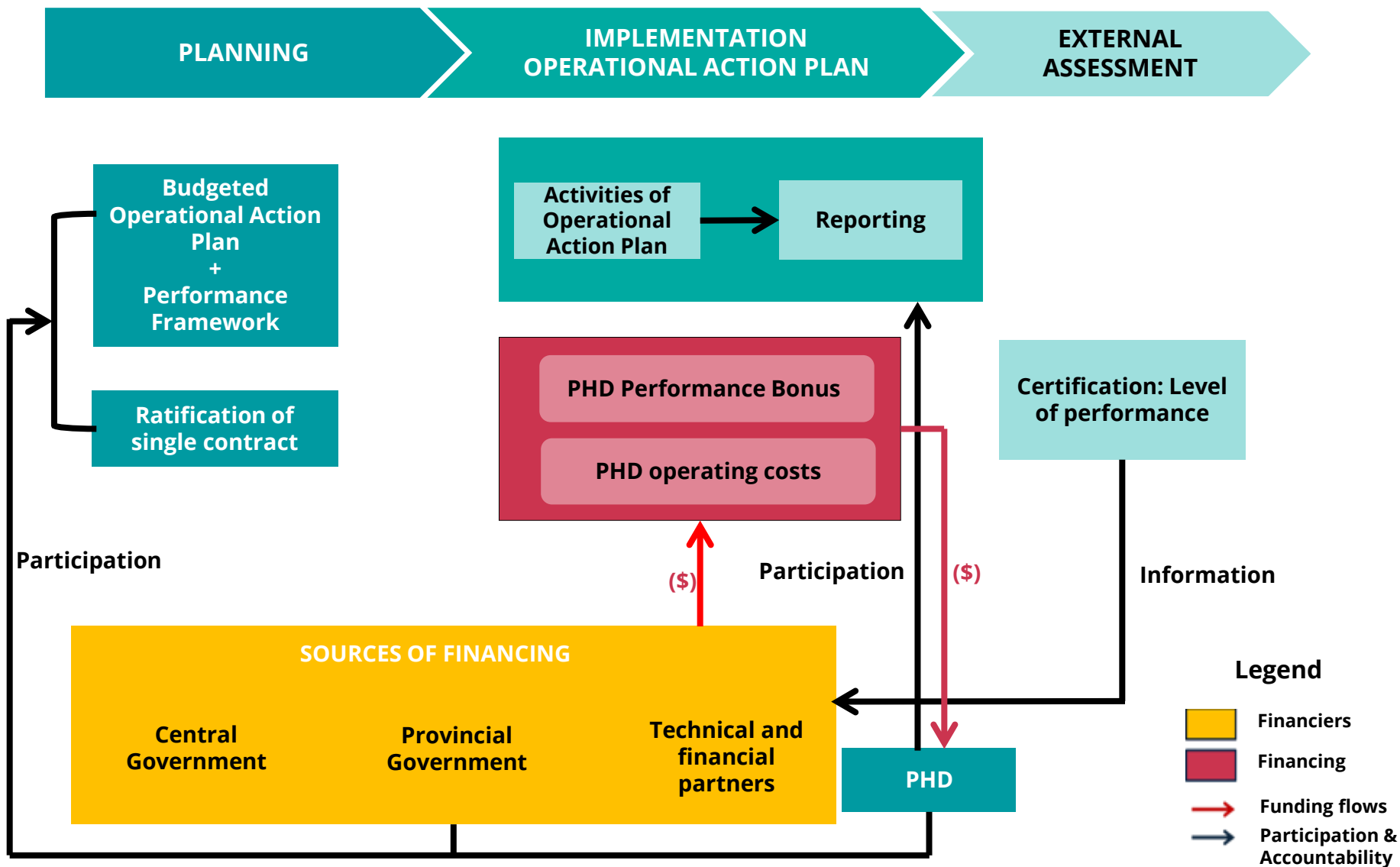
A common performance framework

The single contract includes a single performance framework with indicators focused on the health sector management and coordination at provincial level; cross-sectoral collaboration; technical support and coaching at health zone level; resource management ; and health information management.

This performance framework informs a quarterly evaluation conducted by a three-person team designated by the Provincial Steering Committee. The evaluation takes the form of a meetings during which the current performance of a PHD is compared to the targets and forecasts included in its operational action plan. This comparison generates a performance score.

Performance scores are typically communicated to the Provincial Steering Committee, which forwards them for review to the MSP-HP and the Inter-Donor Health Group (GIBS) – a coordination entity which brings together health sector TFPs.

The Single Contract at the Provincial Health Division level



Alignment to better address health priorities

Single contract at National Level

The single contract also operates at the central level and involves contracting seven MSP-HP services to supervise and coach PHDs [7]. National level services are contracted by the Secretary General for Health and their operational costs are financed by TFPs based on a quarterly work plan. These services include the:

- (1) Directorate for Studies and Planning to ensure compliance with national standards, advocate for the mobilization of external and domestic funding and promote alignment.
- (2) National Reproductive Health Program, (3) the National Adolescent Health Policy, and (4) the National Nutrition Program to provide specialized services.
- (5) Technical Commission for Strategic Procurement to verify and approve payments provided to national bodies.
- (6) Government Financial Management Support Unit to coordinate vertical financing in the health sector. It involves the MSP-HP, the Ministry of Finance, and organizations with vertical programs such as Gavi and the Global Fund.
- (7) Monitoring and Evaluation Unit to monitor services provided by national directorates and national programs based on their performance frameworks.

NB. This knowledge and learning case study only focuses on the single contract at the PHD level only.



4

Democratic Republic of Congo: Single Contract

How did the Single Contract take shape?

Political Economy | Introduction & Adoption of the Single Contract

The introduction of the single contract was facilitated by a conducive political economy, influenced by a favourable reform context, evidence-based decision making, diagnostic convergence, and a participatory conceptualization process.

Initial context

The emergence of the single contract constitutes an extension of the commitments made by the government of the DRC in 2006, and renewed in 2010, to revitalize the decentralized levels of health systems and increase the contextual specificity of its health response [8]. Focusing on intermediate level of the health pyramid as well as on health financing, these commitments assigned PHDs with a coordination, coaching and monitoring role to be implemented at health one level.

This reform context not only contributed to the establishment of new institutional dynamics, but it has also participated in reshaping the relationships among key stakeholders – notably strengthening the link between TFPs and PHDs and between PHDs and health zones.

Diagnostic convergence

In 2014, the evaluation of the 2011-2015 National Health Development Plan [9] and the evaluation of health financing at the intermediate level [10] provided a diagnosis of key bottlenecks at decentralized levels. In particular, they highlighted the:

- Fragmentation of development assistance for health at health zone level.
- Limited capacity of PHDs in terms of aligning technical and financial partners.
- Insufficient coaching and monitoring measures taken at all levels.
- Inefficiency of financial management, particularly due to the multiplicity of contracts and financial procedures that PHDs have to comply with. For example, it was reported that one PHD simultaneously managed 33 contracts.

Political Economy | Introduction and adoption of the Single Contract

Diagnostic convergence (continued)

This diagnostic picture first informed a reflective process led by the Directorate for Studies and Planning (DEP) of the MSP-HP and supported by the World Bank, which generated the initial concept of a single contract in the DRC. Subsequently, the DEP introduced the single contract to key stakeholders and engaged them in an analytical process during the preparation of the 2016-2020 National Health Development Plan. This not only supported a diagnostic convergence in the health sector in DRC, but also fostered a shared desire to devise effective and realistic solutions to existing bottlenecks.

Strategic dialogue

Building on this diagnostic convergence, the DEP conducted targeted consultations with TFPs and a number of PHDs to garner their insights, identify and understand their concerns and ensure the contextual suitability of the single contract.

In general, TFPs agreed that the single contract had the potential to adequately address the need to pool and harmonize financing at the provincial level, while strengthening the coordination role of PHDs. To help strengthen in-country leadership and accountability and foster ownership, they nevertheless insisted on the incremental financial participation of the government at provincial and central levels. They also indicated that their ability to align might be limited, given financial decisions for their institutions were generally taken at headquarters level. In addition, TFPs also expressed concern regarding the integrated nature of the mechanism, the possible dilution of accountability in the context of vertical financing and PHD management capacity.

The eleven PHD leaders consulted were also in favour of the single contract. They however emphasized the need to make provisions to maintain the integrity of the mission of the PHD, to ensure a minimum number of personnel within the PHD and to include measures capable of increasing motivation as well as retaining PHD personnel.

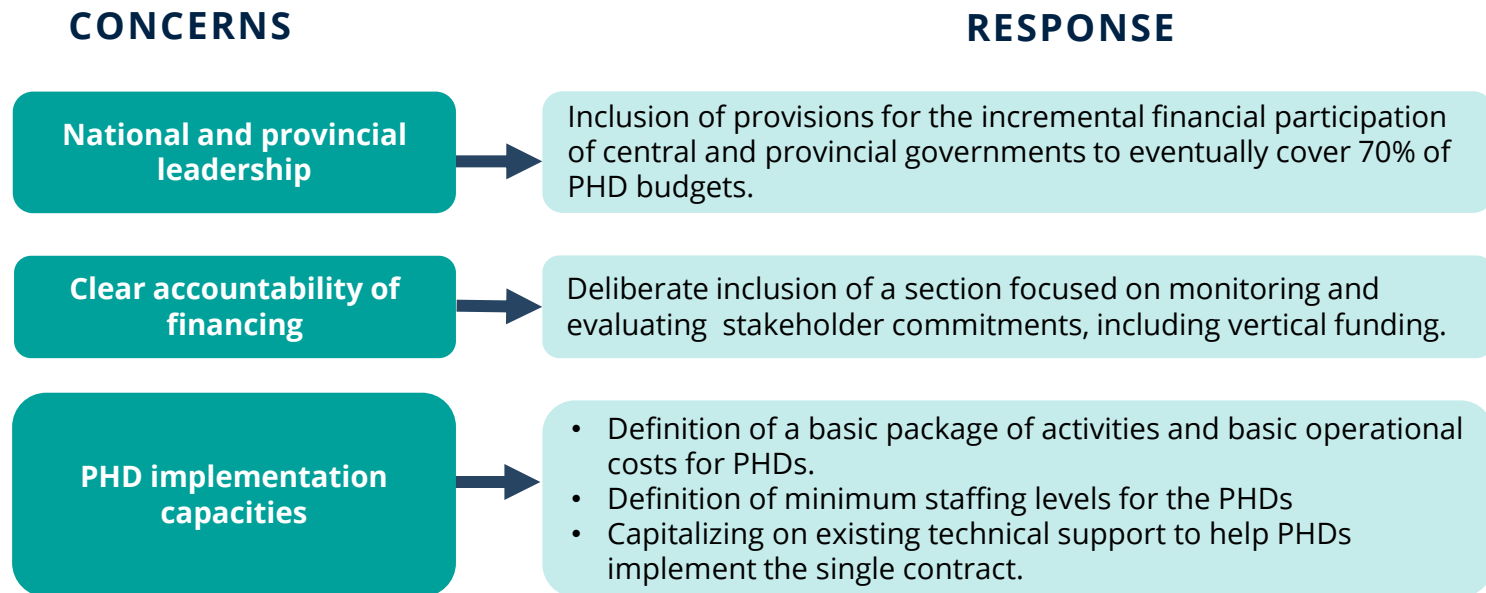
Political Economy | Introduction and adoption of the Single Contract

Formal adoption

In December 2014, the single contract was formally adopted by the National Steering Committee of the Health Sector as a national health policy document.

Participatory design

In 2015, the MSP-HP organized a workshop in Matadi (Central Kongo province) to define the content as well as the implementation process of the single contract. The involvement of key stakeholders in the development of the single contract made it possible to create a common vision, incorporate measures capable of addressing stakeholders' concerns, and to lay the foundations for in-country ownership.



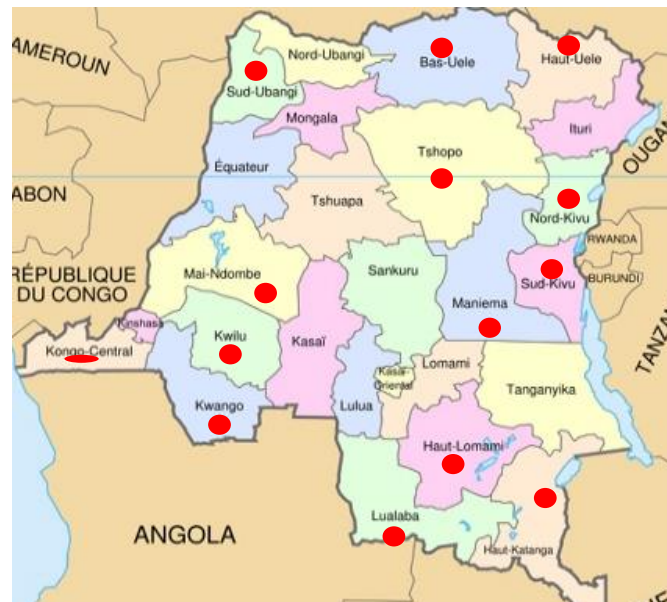
Implementation | Launch of the Single Contract

Launch of the implementation process

The single contract was officially launched by the Secretary General for Health in 2017. Partners engaged with single contract on a voluntary basis and in a phased manner as follows:

1. World Bank.
2. Members of the Health System Development Plan platform, which includes the Global Fund, Gavi, UNFPA, UNICEF and USAID.
3. Other TFPs, including the Belgian Development Agency, the European Union, the Japanese International Cooperation Agency, the Agency for International Cooperation of the Swiss Confederation, ULB-Cooperation, and the World Health Organization.

In October 2022, 14 single contracts were being implemented in the provinces of Bas-Uele, Haut-Katanga, Haut-Lomami, Haut-Uele, Kongo-Central, Kwango, Kwilu, Lualaba, Mai-Ndombe, Maniema, Nord-Kivu, Sud-Kivu, Sud-Ubangi et Tshopo.



Map of the 26 provinces of the DRC

● 14 provinces with a single contract



5

Democratic Republic of Congo: Single Contract

Lessons Learned : Implementation of the Single Contract

Implementation | Lessons learned

Introduction

This section presents the challenges experienced and the lessons learned during the implementation of the single contract, based on the five cross-cutting pillars of the Paris Declaration (i.e., alignment, ownership, harmonization, mutual accountability, and results-based management). It builds on both the interviews and the literature review, particularly drawing from two documentary sources :

- The **Evaluation of the Implementation of the Single contract at the Intermediate Level of the Health System in the Democratic Republic of Congo**, conducted by the World Bank in collaboration with the DEP as part of a series of studies on health financing in the DRC. Published in May 2021, this evaluation was commissioned by the Japanese Trust Fund managed by the World Bank.
- The study on the **implementation process and challenges of the single contract**, conducted by single contract experts and published in December 2021 in the African Journal of Primary Health Care and Family Medicine [11].

NB. *Unless otherwise indicated, the quotations provided are sourced from the qualitative interviews conducted as part of this Knowledge and Learning Case Study (2022).*

Implementation | Lessons learned

Alignment

- Voluntary in nature, the engagement of TFPs remains limited. Support for and alignment with the single contract is hindered by rigid procedures governing some external financing, poor central government involvement and limited trust in PHD financial management capacities.

« Some partners' procedures are not aligned with the single contract approach (late disbursement of funds, different approaches to planning and disbursement, different program procedures, etc.). »

Manager of a Provincial Health Division

- Procedural flexibility can help enhance responsiveness. In North Kivu, for instance, such flexibility allowed the PHD to use financing from ULB-Cooperation to readily respond to the Ebola outbreak.
- The single contract could be a more important tool for aligning external financing to the provinces' operational action plans (OAP). While external financing increased between 2018 and 2019 leading to better structured and more aligned financing, aggregate financing remains low. This might however be explained by the fact that the single contract mechanism only covers PHD operational costs, as opposed to service delivery costs at the health zone level.
- Vertical funding persists and humanitarian activities continue to be implemented in parallel, thereby creating inefficiencies. Humanitarian activities often require PHDs to either modify their OAP and resource allocation procedures or to operate outside of the OAP.

« Some partners introduce activities which do not align with the plan. This disrupts the entire planning process. In the face of weak leadership, they impose themselves and manage to carry out their own interventions. »

Manager of a Provincial Health Division (2022)

Implementation | Lessons learned

Alignment (continued)

- Anecdotal evidence indicates that the active involvement of Provincial Ministries of Health as signatories to the single contracts, including their participation in negotiations, can contribute to improving the autonomy and responsiveness of provincial authorities. Better linking decisions made at provincial and central levels could help reinforce this autonomy and, more importantly, strengthen alignment.
- At the provincial level, TFP representatives often have to refer to their counterparts located either in the capital or at their international headquarters. This lack of decision-making authority causes delays in the implementation of OAPs. To address this challenge, it would be useful to revitalize provincial coordination bodies of TFPs, notably by increasing the frequency of meetings and by implementing an operational provincial GIBS.

« The lack of flexibility in terms of decision making for some local TFP managers, with regard to fund disbursement and justification procedures and the organization of a joint audit, is challenging.»

Manager of a Provincial Health Division

- The leadership of PHDs is not sufficient to support and strengthen the concrete alignment of TFPs.

« ...At times, it is also a question of who is in charge, of how the governing authority assumes its responsibilities... »

Manager of a Provincial Health Division

Implementation | Lessons learned

Leadership & Ownership

- The single contract is generally well understood, as a planning and management tool seeking to promote better alignment in the health sector. It is however not always clear that the single contract does not directly finance health service delivery at health zone level. Consistent and regular communication could help sustain a common vision, reaffirm the role and function of the single contract, and reinforce stakeholder engagement.
- The support provided by central level directorates and programs is deemed insufficient. Reportedly, expectations are seldom communicated and the guidance and tools provided are insufficient. Generating disengagement and demotivation among PHD cadres, this poor engagement at central level has important implications for staff retention, as well as for institutional memory as it pertains to the single contract.

«For some PHDs, the quarterly report that is systematically submitted to the central level – with recommendations concerning the central level – received no response from the recipient. As the regulator and initiator of the single contract, the central level could have been more involved. »

Technical and Financial Partner

« The government partner has very limited resources, but also lacks the leadership to implement its own program. »

Technical and Financial Partner

- The single contract contributes to mobilizing domestic resources and to reinforcing decentralization. The level of domestic resources mobilized nevertheless remains low, as the single contract only supports PHD operational costs (and not service delivery). Between 2018 and 2019, the proportion of total single contract financing covered by the central government had increased from 21% to 39% and the share of financing mobilized by the provinces had increased from 1% to 2%. This increase bodes well for country ownership and sustainability in the long run.

Implementation | Lessons learned

Leadership & Ownership (continued)

- The involvement of provincial health ministers can facilitate dialogue and help resolve bottlenecks. Reportedly, in the provinces of North Kivu and Lualaba, the active participation of provincial health ministers in Provincial Steering Committee meetings helps not only continuously ensure the contextual suitability of the single contract but also address bottlenecks – such as disbursement delays - in a timely fashion. This contributes to strengthening ownership at the decentralized level.

Harmonization

- The OAP is a critical coordination tools which helps harmonize health interventions and minimize duplication. Some PHDs have nevertheless indicated that OAPs need to be more flexible to adapt to the priorities of multiple stakeholders.

« ... The single contract is a tool developed to pool resources based on an action plan agreed upon by the partners – for greater efficiency and transparency, and to avoid duplication. This tool is virtual for the time being... »

Manager from the Ministry of Public Health, Hygiene and Prevention

- The fact that TFPs retain their own procedures, their own performance indicators and their own incentives mechanisms not only creates inefficiencies but also exacerbates PHDs' administrative burden.
- This lack of uniformity highlights the need to develop standard operating procedures and outline them in a single manual. At the very least, performance indicators used at the PHD level should be streamlined. Key informants also recommended standardizing costs to better articulate TFP commitments and increase their predictability.

Implementation | Lessons learned

Harmonization (continued)

- There is an asynchrony exists between PHD planning calendars (December/January) and the legislation governing the preparation of the national budget (July), as well as well as between the financial management calendars of TFPs and that of PHDs. Disbursements are often lower in the first quarter of the year and increase in the third quarter, forcing PHDs to modify the sequencing of their activities and/or simultaneously implement delayed activities and planned activities. This has a significant effect on overall PHD performance and, in turn, on their credibility in terms of financial management. Harmonizing these schedules could help increase the predictability and availability of financing, as well as PHD performance.

Mutual Accountability

- The single contract promotes accountability through the use of a common performance framework.
- Coaching and regular performance evaluations help enhance transparency and foster accountability at provincial level. The 2021 evaluation shows a positive correlation between coaching provided by the central and provincial government authorities and the completion rate of activities outlined in OAPs. The involvement of central and provincial government authorities is however not deemed sufficient and systematic enough to fully leverage this correlation.
- Performance indicators are not uniformly understood, which makes it difficult to conduct evaluations. Evaluation meetings rarely generate feedback for improved performance, and course corrections are not consistently implemented.
- Performance criteria are not always relevant to measure PHD performance. The progressive nature of some indicators is not systematically applied to address performance saturation (i.e., indicators being changed when targets have been met). Given the single contract's structural financing is complemented by performance incentives, this situation may cause demotivation and disengagement at the provincial level.

Implementation | Lessons learned

Mutual Accountability (continued)

« The relevance of the deliverables (with regard to governance, health system strengthening and sustainability) is verified and approved during the performance framework evaluation. In some provinces, the deliverables were reviewed at each evaluation and no change occurred. Deliverables need to be regularly reviewed. »

Manager of a Provincial Health Division

- Accountability is understood as being unidirectional in nature, as it is predominantly rooted in the performance framework and thus directed at them. Some PHD cadres notably indicated that the single contract should include reflexive accountability mechanisms capable of encouraging central and provincial authorities as well as TFPs to honour their commitments and actively participate in the implementation of the single contract.

«Non-fulfillment of commitments by some partners, including late payment of funds, leads to some disruptions or a lack of funds. »

Chief Medical Officer, Health Zone

- The health zones are not particularly involved in developing and monitoring OAPs, limiting their ability to have their needs reflected. In the same vein, civil society does not play an active role in making either the government or TFPs accountable.

Implementation | Lessons learned

Results-Based Management

- The single contract contributes to improving PHD competence in terms of planning, tracking and budgeting. In this regard, the implementation of OAPs is one of the most concrete paths, enabling provinces with a single contract to monitor OAP funding and activities on a quarterly basis. The mechanism provides a transparent evidence-based manner to monitor and showcase performance at provincial level.
- Nevertheless, budgetary execution on the part of the government and TFPs remains weak at the provincial level. In fact, despite the very low mobilization of PHD resources, only one-third of these resources are used. Deriving from poor public financial management capacity, this hinders the implementation of activities and diminishes the credibility of the single contract for TFPs.

« Gaps in management skills remain in some provincial health divisions. »

Manager at the Ministry of Public Health, Hygiene and Prevention

- Single contract disbursement rates are generally low and experience relatively wide geographic variations. This also calls into question the capacity of provinces to absorb single contract resources. In addition, poor record keeping and the low quality of funding requests also contribute to delaying disbursements. In a context of reduced capacity, the multiplicity of financial procedures compounds this low absorption capacity.
- Devolved from the central level, the planning tool was not adapted for the single contract and does not correspond to the new mandate of PHDs, as prescribed by the Health Systems Strengthening Strategy (2006; 2010). This creates inefficiencies in resource management. For example, PHDs sometimes have to manage resources intended for the Provincial Health Inspectorate (IPS), despite having very distinct roles and accountabilities. While PHDs focus on coaching and monitoring the health zones under the aegis of the Provincial Minister of Health, IPSs play a monitoring and inspection role under the leadership of the Provincial Governor. This situation not only increases the workload of PHDs, but also adds to the complexity of public financial management activities under their purview.

Implementation | Lessons learned

Results-Based Management (continued)

«The planning tools are not aligned with the missions of PHDs outlined in the six offices. The national level tools have nothing to do with this.»

Provincial Health Division Officer (World Bank, 2021)

« The justification of funds sometimes poses problems at the level of the Provincial Health Division. For example, some financing purposed for the Provincial Health Inspectorate goes through the Provincial Health Division, creating an overload. »

Technical and Financial Partner

- Technical assistance significantly contributes to enhancing the quality of planning and implementation of the single contract. That was particularly the case in the provinces of Central Kongo with support from Memisa and North Kivu with support from ULB-Cooperation. Technical assistance is however not systematically provided and is not always adapted to the evolving needs of the provincial cadres. A coherent technical assistance plan capable of leveraging existing activities could help strengthen competence at individual and institutional levels.
- The OAP development process does not always involve TFPs and does not generally take into account the needs of health zones.

Factors for Good Performance

The provinces that perform well in terms of coaching, activity completion rates and disbursement are those that combine:

- Optimal planning with an operational action plan developed in a participatory manner with health zones, community-based organizations and civil society organizations.
- Compliance of technical and financial partners with their financial commitments.
- PHD ownership of mechanism.
- Regular consultation with the active participation of all key stakeholders.

Evaluation of the implementation of the single contract at the intermediate level of the health system in the Democratic Republic of Congo. World Bank, 2021.



4

Democratic Republic of Congo: Single Contract
Stakeholder Reflections

Reflections | Keys to Success

This section draws on lessons learned from implementation as well as stakeholder reflections and recommendations to identify the pre-conditions required to roll out the single contract. These pre-conditions are presented on the basis of the five cross-cutting pillars of the Paris Declaration (i.e., alignment, ownership, harmonization, mutual accountability and managing for results).

Reflections | Keys to Success

Alignment

Appropriation

Harmonization

Mutual Accountability

Results-based Management

- Deliberate alignment with national health priorities and national public financial management policies and practices.
- A common space for dialogue and negotiation with a functional and inclusive coordination mechanism at both central and provincial levels
- Decision-making authority is given to provincial government authorities and representatives of technical and financial partners at the provincial level.
- The operational action plan is flexible and adapted to the context and priorities of various stakeholders to promote alignment.
- Aggregate financing, including vertical financing, is aligned with the operational action plans.

Reflections | Keys to Success

Alignment

Appropriation

Harmonization

Mutual
Accountability

Results-based
Management

- Strong national leadership capable of catalysing and sustaining the changes brought about by the single contract.
- Intrinsic country leadership (rather than extrinsic and driven by TFPs) strengthened by a balance of resources and power
 - Balance of resources and power crystallized by provisions for an incremental financial participation of the government at central and provincial level.
- High-level championing reinforced by a shared vision and open, consistent and regular communication to encourage buy-in and performance and legitimize and support change.

Reflections | Keys to Success

Alignment

Appropriation

Harmonization

Mutual
Accountability

Results-based
Management

- Common standard operational procedures are available and captured in a shared manual.
- The processes inherent to the single contract are flexible and involve the continued participation of key stakeholders, including health zones and TFPs.
- Costs are standardized and shared budgets include contingency plans.
- Financial management agendas are harmonized across stakeholders and administrative levels.

Reflections | Keys to Success

Alignment

Appropriation

Harmonization

**Mutual
Accountability**

**Results-based
Management**

- Credible incentives mechanism are included to ensure commitments are fulfilled by technical and financial partners and the central government. This mechanism is aligned with national accountability systems.
- An incentive mechanism, combining financial bonuses with regular coaching, is incorporated into the single contract at the provincial level.
- A functional, evidence-based coaching and supervision mechanism supported by a learning strategy underpins the single contract. Course corrections are defined in a participatory manner and coaching is systematically provided for their implementation.
- Performance framework indicators and the theory of change of the single contract are clearly defined, streamlined and communicated. In addition, performance criteria are regularly reviewed to ensure their relevance and contextual suitability.
- Key stakeholders, including health zone personnel, civil society and the community, participate fully in monitoring and evaluating single contract-related activities.

Reflections | Keys to Success

Alignment

Appropriation

Harmonization

Mutual
Accountability

Results-based
Management

- The operational action plan is adapted to ensure consistency with the mandate of the PHD and single contract requirements.
- Planning is inclusive and participatory. It includes key stakeholders from the national, provincial and local levels (i.e. health zones) as well as the TFPs and their representatives at provincial level.
- The central level actively supports and coaches PHDs, particularly to encourage buy-in and performance.
- PHDs are credible and capable in terms of public financial management.
- A joint technical support strategy leveraging existing and/or already funded activities supports the implementation of the single contract.
- A staff retention strategy and a knowledge management strategy are developed to ensure continuity, competency and institutional memory.
- Job descriptions are streamlined to avoid excessive workloads and clarify roles and responsibilities.

Reference notes

[1] Demographic and Health Surveys, 2013-2014

[2] [4] National Health Accounts 2018. Published in 2020

[3] [5] Health Budget. Ministry of Public Health. 2019

[4] National Health Accounts 2018. Published in 2020

[6] Mutombo Beya P, Milumbu Mulumbulwa, G. Evaluation of the implementation of the Single Contract at the intermediate level of the health system in the Democratic Republic of Congo. World Bank, 2021.

[7] National Guidelines for Financing Ministry of Public Health Administrative Structures at Intermediate and Central Levels under the Plan for Health Systems Development. Ministry of Public Health, Hygiene and Prevention, 2019

[8] Health Systems Strengthening Strategy. DRC Ministry of Public Health, Hygiene and

Prevention, 2006 & 2010

[9] Comprehensive Sector Review of the Evaluation of the 2011-2015 National Health Development Plan. Ministry of Public Health, Hygiene and Prevention, 2014

[10] Report on the Financing of Provincial Health Divisions in the Democratic Republic of Congo. Directorate for Studies and Planning, DRC. 2014.

[11] Bisimwa G, Makali SL, Karemere H, Molima C, Nunga R, Iyeti A, Chenge F. Single Contract, an Innovative Approach to Financing the Intermediate Level of the Health System in the Democratic Republic of Congo: Implementation Process and Challenges. *Afr J Prim Health Care Fam Med*. 2021 Dec 6;13(1):e1-e9. doi: 10.4102/phcfm.v13i1.2869. PMID: 34879695; PMCID: PMC8689365.

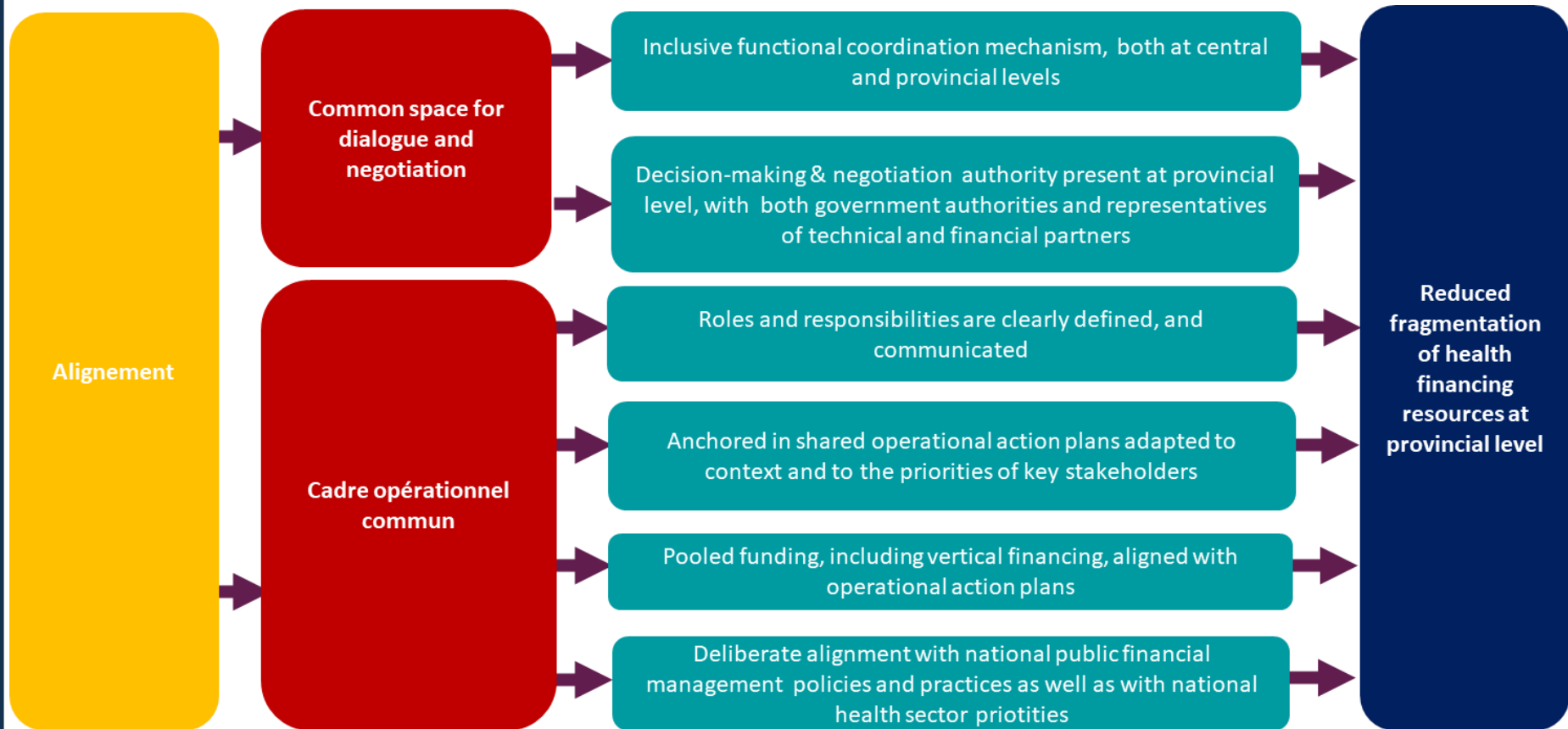


Democratic Republic of Congo: Single Contract
Annex: Analytical Framework

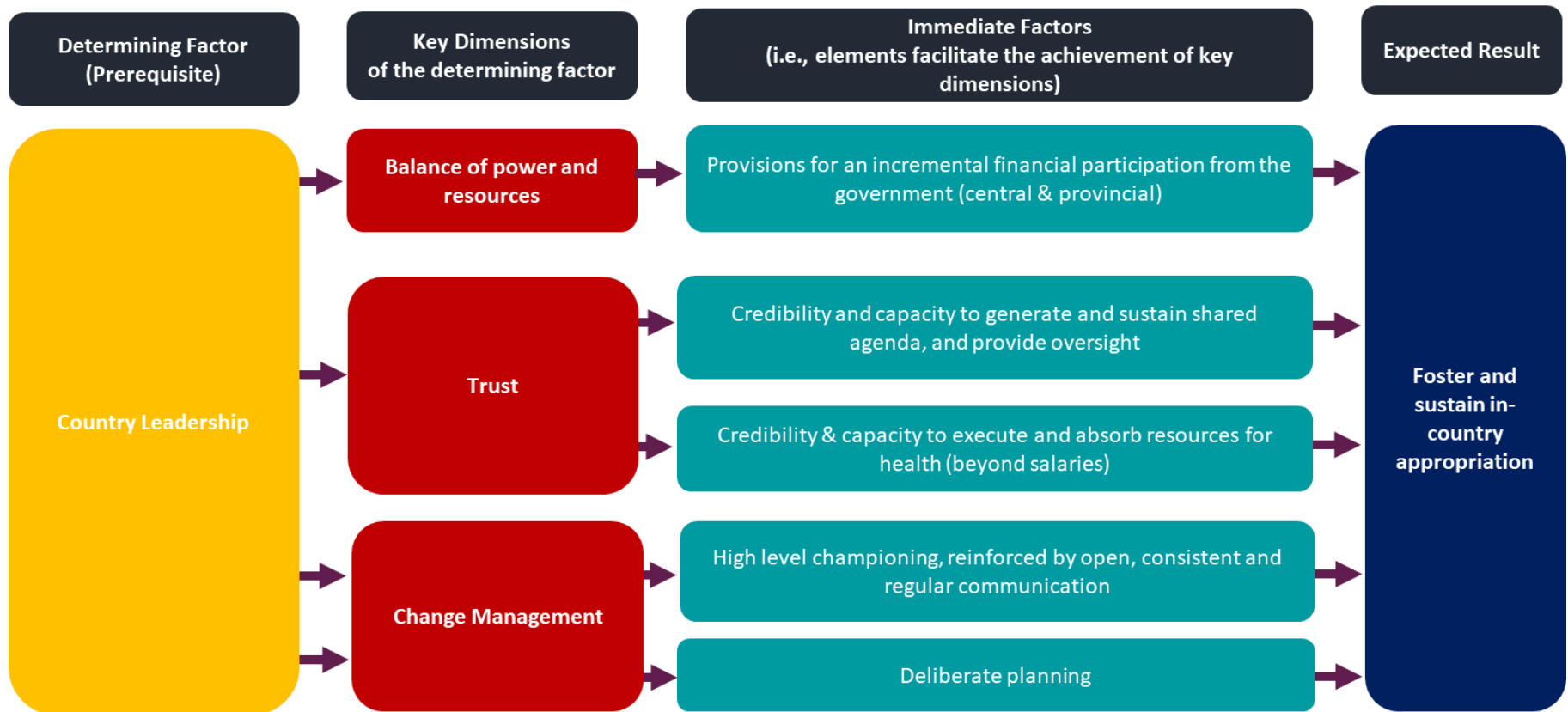
Analytical Framework | Single Contract

The results of this Knowledge and Learning Case Study have been used to develop an analytical framework, outlining pre-conditions for rolling-out the single contract. While it is not comprehensive in nature, it is provided here to inform further reflections on the operationalization, scale up and replication of the single contract.

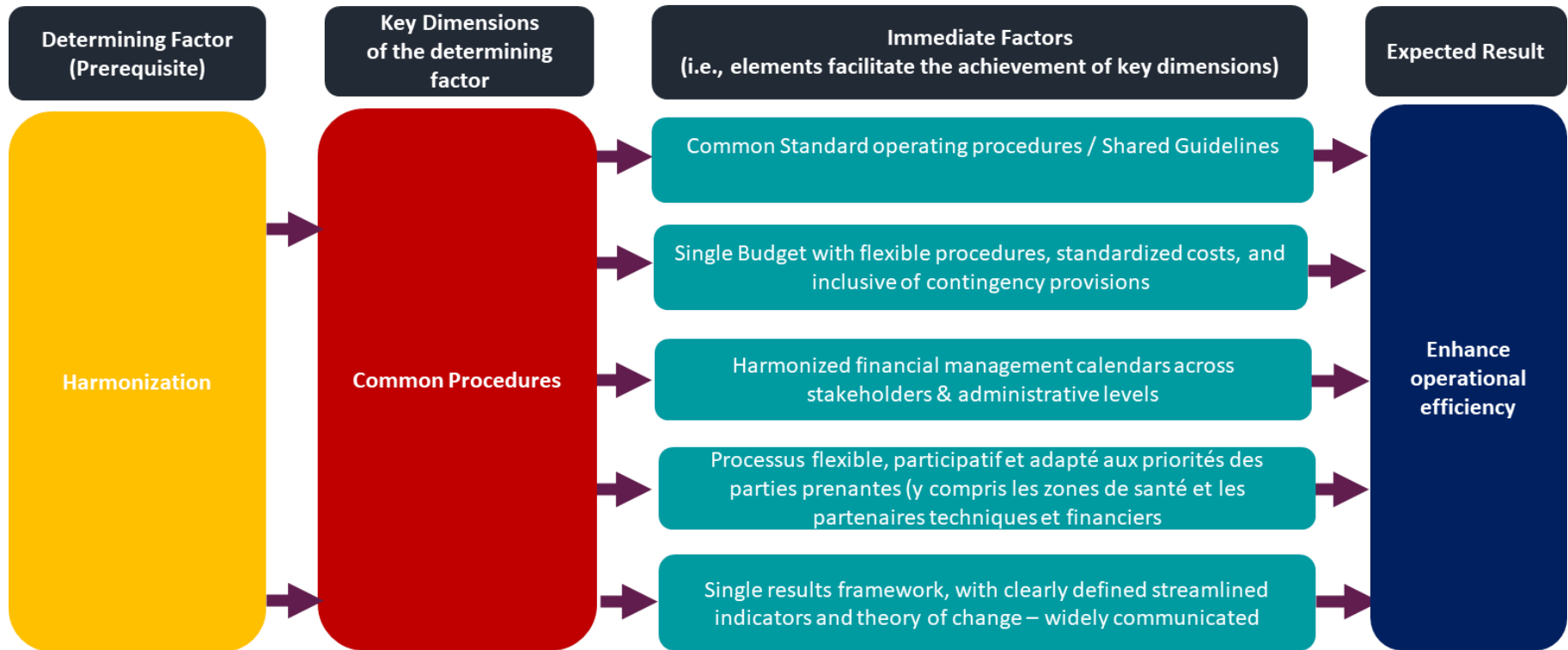
Alignment



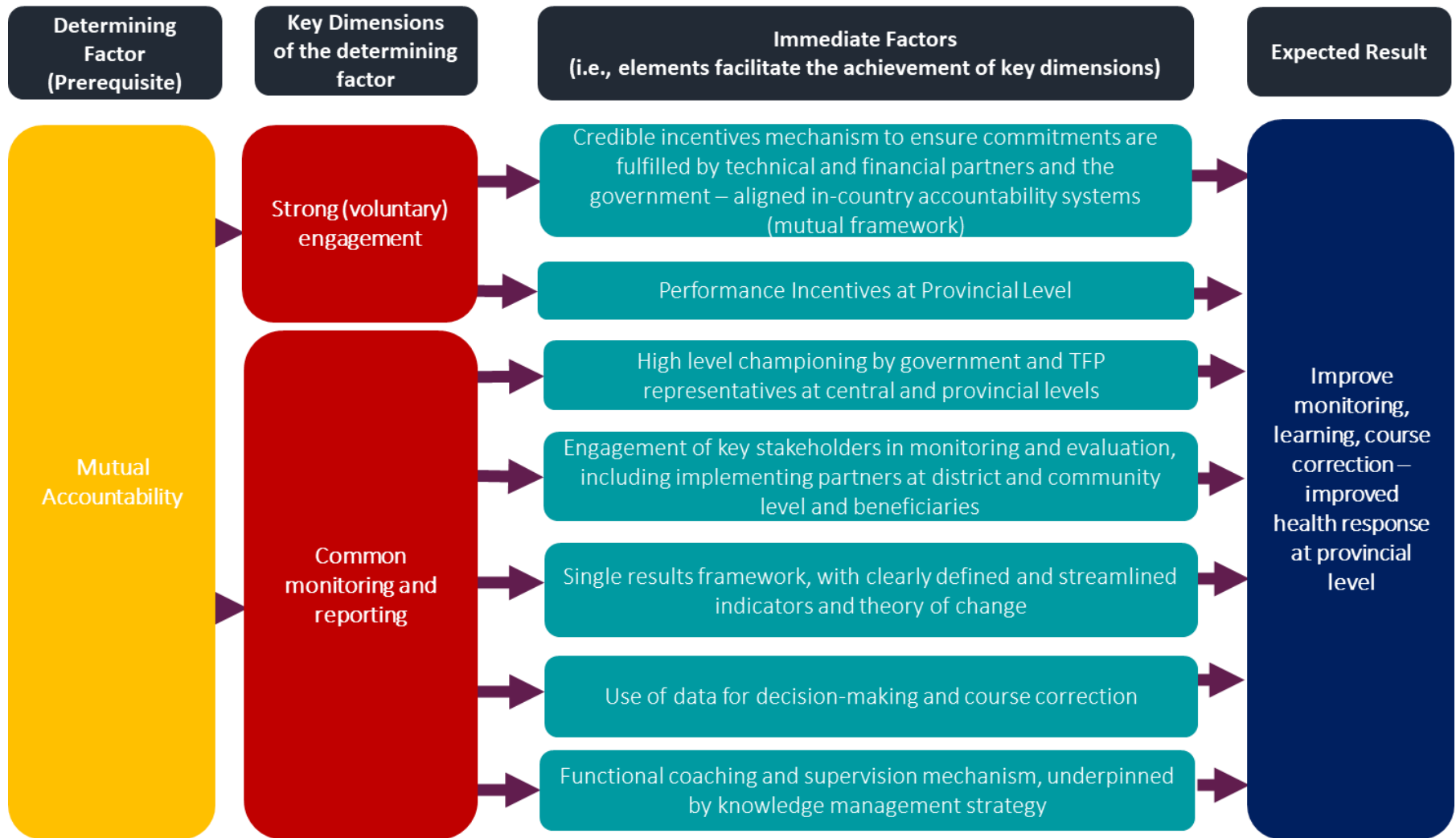
Analytical Framework | Single Contract: Appropriation



Analytical Framework | Single Contract: Harmonization



Analytical Framework | Single Contract: Mutual Accountability



Analytical Framework | Single Contract:

